

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>2 mos. 7 dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1231 K St. S. E.</b> d. STREET ADDRESS <b>1231 K St. S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Jessie</b> First Middle Last <b>Abney</b>					4. DATE OF DEATH Month Day Year <b>Dec. 6 19 65</b>				
5. SEX <b>female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/2/1886</b>		9. AGE (In years last birthday) <b>79</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tenant farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTH PLACE (County & State, or foreign country) <b>Saluda, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>decedent</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary embolism, site of origin undetermined</b> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>generalized arteriosclerosis with arteriosclerotic heart disease</b> (c) <b>rheumatic heart disease, by history; chronic pyelonephritis; diabetes mellitus; left leg amputation, above knee, due to gangrene.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>diabetes mellitus; left leg amputation, above knee, due to gangrene.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Unknown</b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>9/29 1965</b> , to <b>12/6 1965</b> , that (I) (we) last saw the deceased alive on <b>12/6 1965</b> , and that death occurred at <b>1:30 P.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Moe Weiss</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/6/65</b>		
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>					22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-10-65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Mem Park Co</b>		23d. LOCATION (City, town or county) (State) <b>Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>DEC 13 1965</b>	
24. FUNERAL DIRECTOR <b>George H. Better</b>		ADDRESS <b>1203 Valley Rd</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

SECRET

SECRET

Prince George  
Glen Dale (Mrs.)  
Glen Dale Hospital  
Jaslin  
LIVESTOCK  
Salem, S. C.  
Unknown

no  
None  
discharge  
primarily cardiac, also of origin undetermined  
cardiac, with arteriosclerosis of the aorta  
The heart disease  
chronic heart disease, by history; chronic pyelonephritis;  
diabetes mellitus; late in pregnancy, gave birth to a female.

12-15-62  
Glen Dale Hospital  
Glen Dale, Maryland  
Mrs. W. H. H. H.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16773

20157

7

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> c. LENGTH OF STAY IN 1b <b>3 1/2 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PRINCE GEORGES COUNTY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> d. STREET ADDRESS <b>12611 SAFETY TURN, BOWIE, MD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Clayton B. Aldrich</b>		4. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>1965</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 16, 1893</b>		9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMACIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DRUGGIST</b>				11. BIRTHPLACE (County & State, or foreign country) <b>TAUNTON, MASS.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>CASSIUS M. ALDRICH</b>								14. MOTHER'S MAIDEN NAME <b>MARY HANNAH BARRY</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>577-05-9217</b>				17. INFORMANT <b>James J. Torrillo (Son-in-law)</b>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerotic heart disease with</b> DUE TO <b>old myocardial infarction and right bundle branch block</b> (c)												INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>emphysema, pulmonary, chronic with frequent acute asthmatic like attacks</b>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) <del>was present</del> attended the deceased from <b>Nov 27</b> , 19 <b>62</b> , to <b>Dec 24</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec 22</b> , 19 <b>65</b> , and that death occurred at <b>1:29 PM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>John Cosma M.D.</b>								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>Dec 24, 1965</b>							
22c. PHYSICIAN'S NAME (Type) <b>John Cosma, M.D.</b>								22d. ADDRESS <b>3010 Stonybrook Drive, Bowie, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>12-28-1965</b>				23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL CEMETERY</b>				23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>							
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>								ADDRESS <b>5130 Wisconsin Ave. N.W. Wash. DC.</b>				25a. REC'D BY REGISTRAR <b>JAN 3 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

SECRET

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Copyright



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

16774

20158

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>48 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u> d. STREET ADDRESS <u>2709 Virginia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Harry</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8-18-1892</u> 9. AGE (In years last birthday) <u>73</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal Bather</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		<b>4. DATE OF DEATH</b> <u>Dec. 9 1965</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Clinton, Illinois</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>William Armstrong</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW 11</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Edith Drum</u> <b>16. SOCIAL SECURITY NO.</b> <u>577 10 4319</u> <b>17. INFORMANT</b> <u>Richard B. Farr</u> <u>7720 Walker Mill Rd. Washington D.C.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>6/9/1963</u> , <b>to</b> <u>12/9/1965</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12/8/1965</u> , <b>and that death occurred at</b> <u>2:35 AM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Dr. Frederick E. Musser</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Frederick E. Musser</u>				<b>22b. DATE SIGNED</b> <u>12/9/65</u> <b>22d. ADDRESS</b> <u>4410 74th Avenue, Bellemead, Maryland</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/13/65</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Francis Gasch's Sons</u>		<b>ADDRESS</b> <u>Hyattsville, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 13 1965</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>							

MEDICAL CERTIFICATION

20772

20152

CHURCH, ALBERT

1900-1901

1910-1911

Yes

1910-1911

1910-1911

1910-1911

1910-1911

1910-1911

1910-1911

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

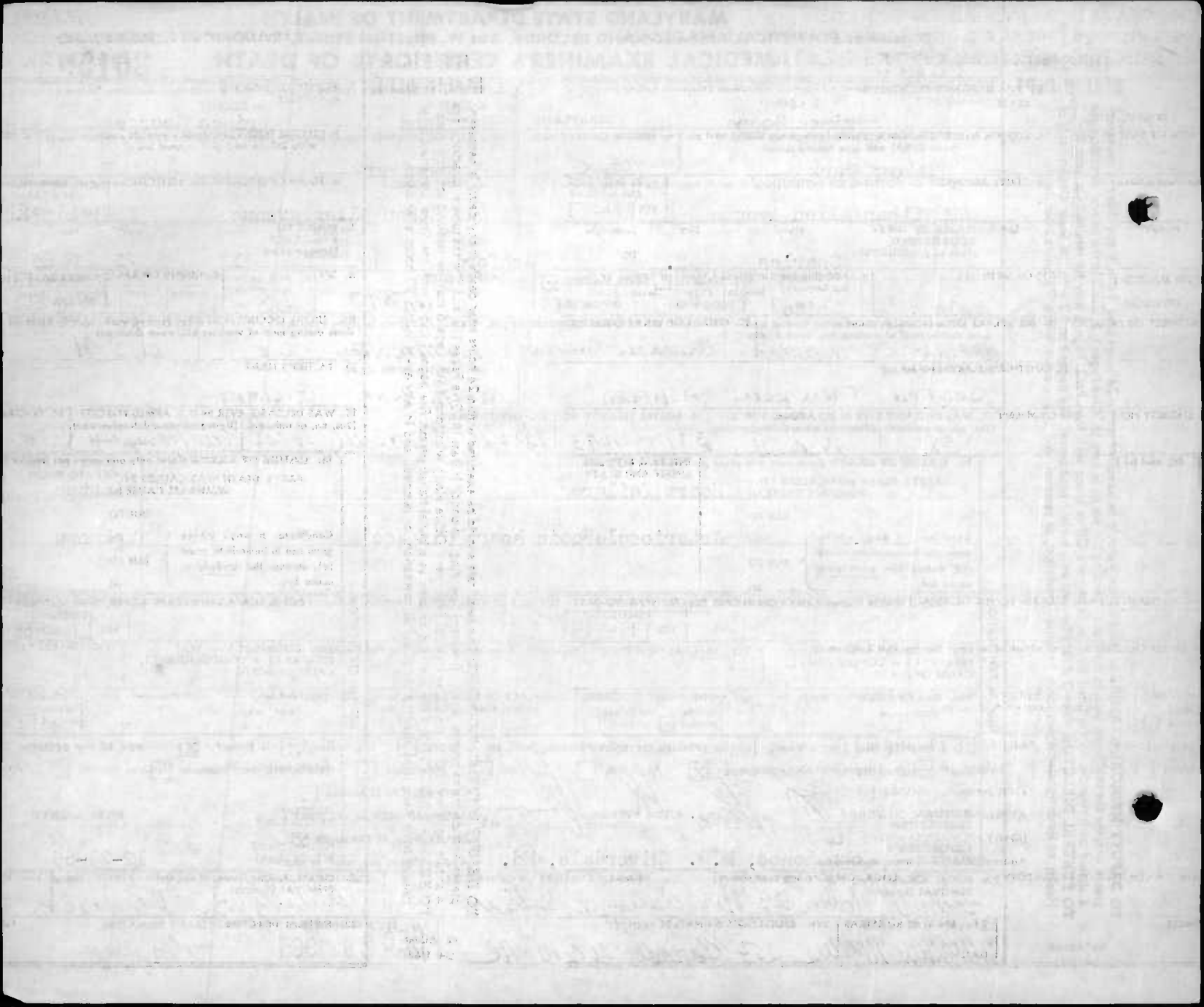
VR A15ME  
5M 1/63

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16775

20159

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 428 Ethan Allen Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles R. Ashford				4. DATE OF DEATH Month Day Year 12 22 19 65					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1897 68 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC'S HELPER				10b. KIND OF BUSINESS OR INDUSTRY 13 BROMWELL FIREPLACE		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH FRANKLIN ASHFORD				14. MOTHER'S MAIDEN NAME GEORGINA GRIMES					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. W.W.T. 579-01-1693		17. INFORMANT Address Burton Bromwell, 10704 New Hamp Ave S.E. Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-23-65			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec 28, 1965		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR J. Arthur Walter, 254 Carroll St NW DC				ADDRESS		24a. REC'D BY REGISTRAR DEC 29 1965		24b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LANHAM MD</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MAGNOLIA NURSING HOME</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MARLOW-HGTS</u> d. STREET ADDRESS <u>2342-KIRBY DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>OLIVE MAE BEALL</u>						<b>4. DATE OF DEATH</b> Month Day Year <u>12 12 1965</u>											
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10/3/1890</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>VIRGINIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>CHARLES ALSOP</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>CORNELIA McDONALD</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT</b> Address <u>ELENOR VANCE 3908 PA. AVES. E. WASH. D.C.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>334X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <table border="1"> <tr> <td>           (b) <u>Stroke</u>            (c) <u>Pneumonia</u> </td> <td> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>1 day</u>  <u>1 WK</u>  <u>4 days</u> </td> </tr> </table>										(b) <u>Stroke</u> (c) <u>Pneumonia</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 day</u> <u>1 WK</u> <u>4 days</u>						
(b) <u>Stroke</u> (c) <u>Pneumonia</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 day</u> <u>1 WK</u> <u>4 days</u>																
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct</u> , 19 <u>65</u> , <b>to</b> <u>Nov</u> , 19 <u>65</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>19</u> , <b>and that death occurred at</b> <u>6A</u> M, <b>from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>[Signature]</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12/13/65</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>3408 R.I. Que. Mt. Rainier</u>						<b>22d. ADDRESS</b> <u>LEON R. LEVITSKY</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>12/15/65</u>				<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR HILL</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>SCITLAND, MD.</u>									
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>R.A. Mattingly 131-11th St. S.E.</u>						<b>25a. REC'D BY REGISTRAR</b> DATE <u>DEC 17 1965</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>									





RECEIVED OF DEATH

1910

Handwritten text, mostly illegible due to fading and bleed-through. Visible fragments include:  
- "Charles" (appearing multiple times)  
- "female" (appearing multiple times)  
- "1910" (at the bottom left)  
- "1911" (at the bottom center)  
- "1912" (at the bottom right)  
- "1913" (at the bottom right)  
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- "2000" (at the bottom right)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16777

## CERTIFICATE OF DEATH

20161

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo s</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL-Upper Marlboro</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL-Upper Marlboro</b>			
c. LENGTH OF STAY IN 1b <b>Life</b>				d. STREET ADDRESS <b>RFD 1707</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RFD 1707</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Edwin</b> Last <b>Bean</b>				4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>19 65</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 9, 1907</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Forestville, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>A rconious W. Bean</b>				14. MOTHER'S MAIDEN NAME <b>Jane Louise Tolson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown --</b>				16. SOCIAL SECURITY NO. <b>--</b>			
17. INFORMANT <b>Mrs. Dorothy Fenno Bean-</b>				Address <b>Same as Item #2.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple metastases</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of left main bronchus &amp; lung</b> DUE TO (c) <b>6 mos!</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos!</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1 Dec 1965</b> to <b>17 Dec 1965</b> , that (I) (we) last saw the deceased alive on <b>16 Dec 1965</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert B. Sasser, M. D.</b>				22b. DATE SIGNED <b>12/17/65</b>			
22c. PHYSICIAN'S NAME (Type) <b>Robert B. Sasser, M. D.</b>				22d. ADDRESS <b>Upper Marlboro, Maryland:</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/20/65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Forestville Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 27 1965</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Ritchie Bros. Upper Marlboro, Md.

DEC - 1965

12/20/65

Burial

Epiphany Cemetery

Forestville

Maryland

Robert B. Sasser, M.D. Upper Marlboro, Maryland:

12/17/65

Unknown --

Mrs. Dorothy Berno Berno - 2.

Same as item

A. Thomas W. Berno

Jane Louise Tolson

Own Farm

Forestville, Maryland U. S. A.

Tobacco Farming

Male

White

March 9, 1907

28

December 17,

65

Jane

Edwin

Bern

RED 1707

RED 1707

X

RURAL-Upper Marlboro

Male

RURAL-Upper Marlboro

Prince Georges

Maryland

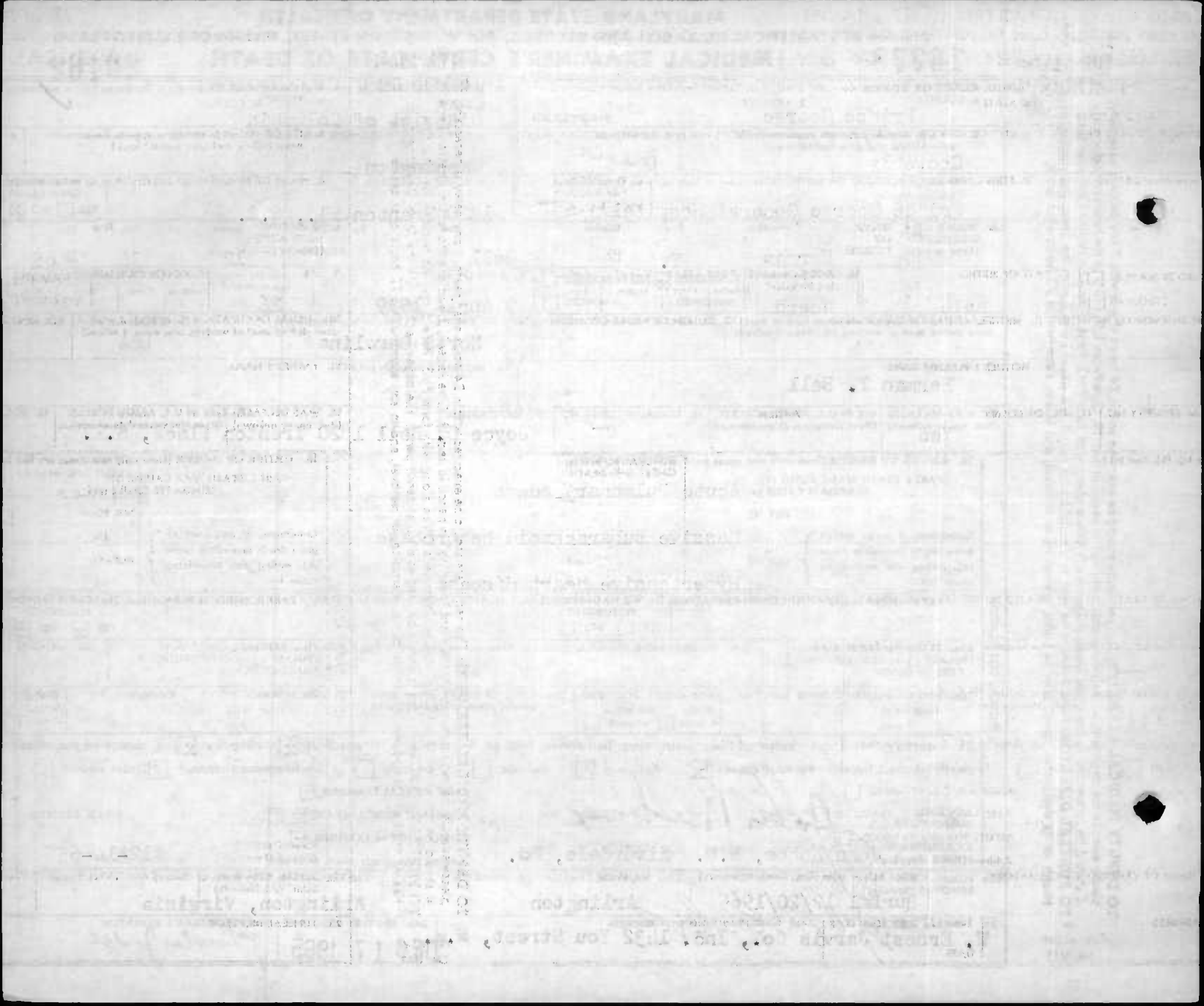
Tr. Geo. S.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME  
5M 1/63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<div style="display: flex; justify-content: space-between;"> <div> <p>16778</p> <p>Item #11 Film #G372 12/27/65</p> </div> <div> <p>20162</p> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <u>District of Columbia</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>471-3</u> d. STREET ADDRESS <u>1820 Trenton Pl., S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Herman</u> Middle <u>T.</u> Last <u>Bell</u>						<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>14</u> Year <u>1965</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 April 1939</u>		9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman T. Bell</u>						14. MOTHER'S MAIDEN NAME <u>Rowena Cox</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joyce C. Bell</u> Address <u>1820 Trenton Place, S.E.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive subarachnoid hemorrhage</u> DUE TO (c) <u>Hypertensive heart disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
18a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>John Kehoe</u> M.D. EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> Riverdale, Md. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-14-65</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Buried 12/20/1965</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>					
23. FUNERAL DIRECTOR <u>W. Ernest Jarvis Co., Inc.</u> ADDRESS <u>1432 You Street, N.W.</u>						24a. REC'D BY REGISTRAR <u>DEC 17 1965</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16779

20163

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY in 1b DOA		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale		d. STREET ADDRESS 6306 46th. Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last Raymond Kinglerly Bell		4. DATE OF DEATH Month Day Year 12 13 19 65		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 July 1894		9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY TRUCK		11. BIRTHPLACE (State or foreign country) DAUPHIN, PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH BELL		14. MOTHER'S MAIDEN NAME HATTIE BELL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 197-10-7048		17. INFORMANT LENA BELL - 6306-46 Ave											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														INTERVAL BETWEEN ONSET AND DEATH minutes unknown													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-13-65											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL														22b. DATE THEREOF 12/16/65		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L		22d. LOCATION (City, town, or county) ARLINGTON, VA.		23. FUNERAL DIRECTOR W.W. CHAMBERS Co. Riverdale, Md.		24a. REC'D BY REGISTRAR DEC 15 1965		24b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

YES MMT.R.II 197-10-2048 Low Dec - 1906 - 40  
 90264H Bear Unknown  
 Shermans (Belied) Track  
 M.S.A

421

Dr. J. H. H. H. H.

Therapsid (Mammal) Track

90256H 90256H

~~2~~

Dr. IWW

107-10-2048 Texas Bank - 2300 - 20

1940

Received of Mr. J. J. ...

Approved by Dr. John Kehoe.  
Deputy Med. Examiner  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
16780 CERTIFICATE OF DEATH 20164												
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges Gen. Hosp.</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>4301 - Kaywood Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Leonard A. Blush</b>			First <b>A.</b>		Middle <b>Blush</b>		Last <b>Dec.</b>		4. DATE OF DEATH <b>5 1965</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/1/1903</b>		9. AGE (In years last birthday) <b>62 yrs.</b>		10. FINDER 1 YEAR Months Oays Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt. - Ret.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Edwin H. Blush</b>					14. MOTHER'S MAIDEN NAME <b>Gertrude B. McDonald</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>579-10-0996</b>		17. INFORMANT <b>Mrs. Mary L. Blush (above address)</b>				Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (Wife)</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic Heart Disease 2 years</b> OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>6 Hours</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)												
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1964</b> to <b>Dec 5, 1965</b> , that (I) (we) last saw the deceased alive on <b>Dec 5, 1965</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.												
22a. SIGNATURE <b>Samuel J. N. Sugar</b>					22b. DATE SIGNED <b>12-5-65</b>			22c. PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR</b>			22d. ADDRESS <b>4657 EASTERN AVE WASH DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/8/65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>					
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>				ADDRESS <b>Mt. Rainier, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 10 1965</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

16781

Item #12 Film #G372 1/3/66 pc

Reg. Dist. No. 20165

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLCREST HTS</u>				c. LENGTH OF STAY IN lb <u>15 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5630 23rd PARKWAY</u>				e. STREET ADDRESS <u>5630 23rd PARKWAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>VINCENZA</u> Middle <u>DEL</u> Last <u>BROCCO</u>				<b>4. DATE OF DEATH</b> 12-23 1965			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 8, 1891</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOSEPH OLIVETTI</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>MRS PHYLLIS ROBERTSON 5630 23rd PARKWAY HILLCREST HTS</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable CVA.</u>							
443X DUE TO <u>Hypertensive cardiovascular disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8-23</u> , 19 <u>65</u> , to <u>9-11</u> , 19 <u>65</u> that I last saw the deceased alive on <u>9-11</u> , 19 <u>65</u> , and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Impul A. Peric</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>MIGUEL A. HUICI</u>				<u>5800 LIVINGSTON RD. WASH. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-27-65</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENSBURG CATHOLIC</u>		22d. LOCATION (City, town, or county) (State) <u>GREENSBURG, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W CHAMBERS, 517 HAST SE</u>				ADDRESS <u>DEC 28 1965</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
20166											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxen Hill						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 5410 Thompson Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Herbert			First Herbert		Last Brown		4. DATE OF DEATH Month December Day 27 Year 19 65				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1900		9. AGE (In years last birthday) 65 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Brange		11. BIRTHPLACE (County & State, or foreign country) Md			12. CITIZEN OF WHAT COUNTRY? D.S.A				
13. FATHER'S NAME Boss Brown				14. MOTHER'S MAIDEN NAME H. Victoria Campbell							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Alice J. Campbell Address Same as 2D					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1419 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the Tongue, Metastatic (c) and Terminal										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 22, 1965, to Dec. 27, 1965, that (I) (we) last saw the deceased alive on Dec. 27, 19 65, and that death occurred at 11:05 PM, from the causes and on the date stated above.											
22a. SIGNATURE C. Louis Mendel						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 28, 1965			
22c. PHYSICIAN'S NAME (Type) C. Louis Mendel, M.D.						22d. ADDRESS 4410 74th Ave. Bellemead, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-31-65		23c. NAME OF CEMETERY OR CREMATORY Holy Family Cem			23d. LOCATION (City, town or county) (State) Woodmore Md				
24. FUNERAL DIRECTOR Henry S. Washington & Sons - 4925 Newmarket Rd				ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 30 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16783

20167

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville d. STREET ADDRESS 3417 Tulane Drive Apt. 24		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital					
3. NAME OF DECEASED (Type or print) Donald First James Middle Brownnett Last		4. DATE OF DEATH Dec. 21 Month Day Year 19 65			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1932	9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY University of Md		11. BIRTHPLACE (State or foreign country) Hudson New Jersey	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Milton Brownnett			14. MOTHER'S MAIDEN NAME Cecelia Boyle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no			16. SOCIAL SECURITY NO. 137 26 7982		
17. INFORMANT Sharon F. Brownnett W Hyattsville, Md. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status asthmaticus 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial asthma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes 20 years					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Riverdale, Md. Address (Street, city, town, or county)		
DATE SIGNED 12-22-65					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 24, 1965		22c. NAME OF CEMETERY OR CREMATOR St Gertrude	
22d. LOCATION (City, town, or county) Rahway New Jersey		(State)			
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. ADDRESS			24a. REC'D BY REGISTRAR DEC 27 1965 DATE		
24b. REGISTRAR'S SIGNATURE J Charles Judge					





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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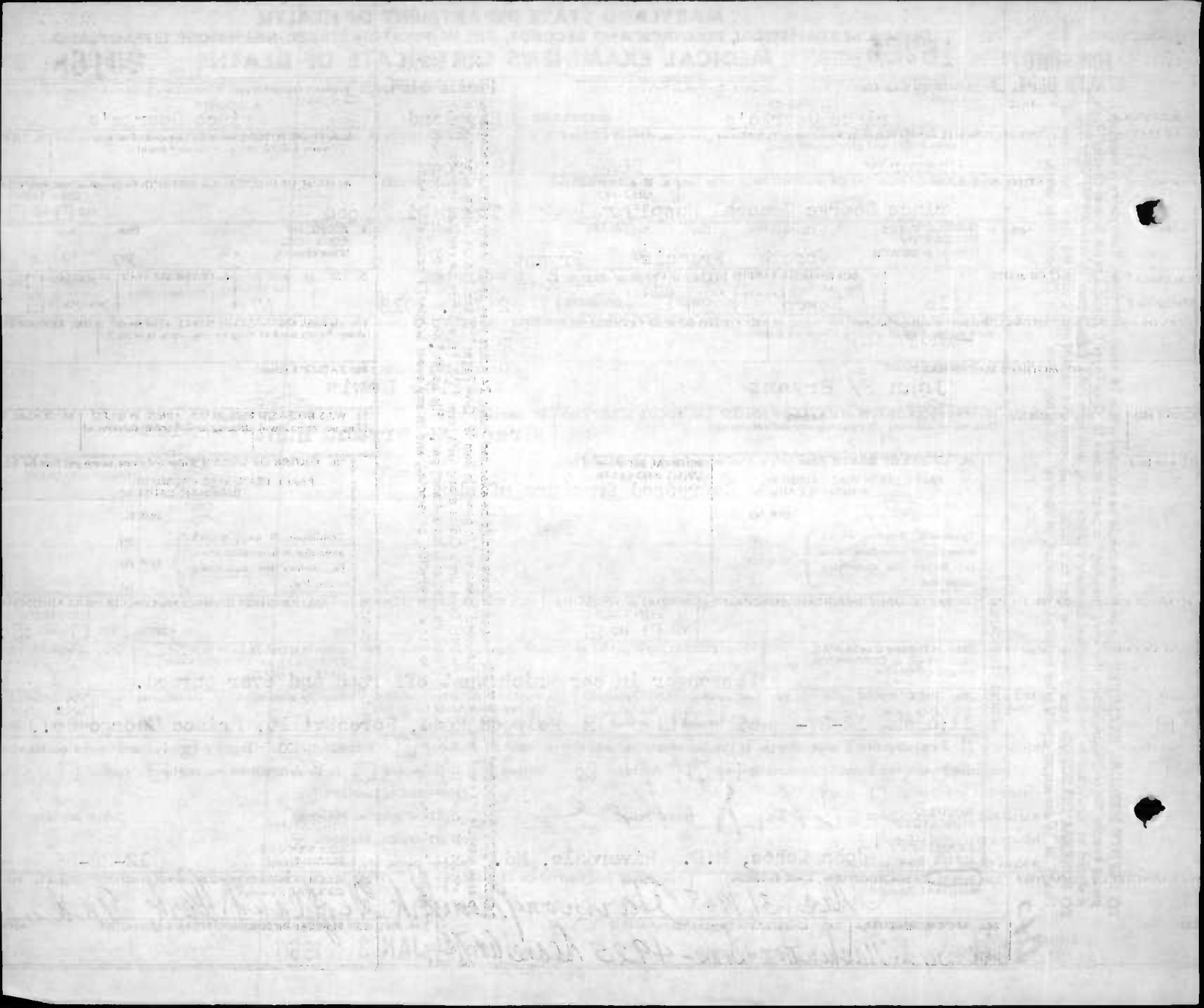
## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16784

20168

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Croom</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trump Hill Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph Francis Bryant</b>				4. DATE OF DEATH <b>12 27 19 65</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12 Jan. 1918</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John F/ Bryant</b>				14. MOTHER'S MAIDEN NAME <b>Alice Lewis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Grace A. Bryant Hunt</b> Address <b>----Sister</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Depressed fracture of skull</b> <b>8234</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car which went off road and over turned.</b>					
20c. TIME OF INJURY Month, Day, Year <b>11:41 a.m. 12-27- 1965</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> <b>Melwood Road, Forestville, Prince George Co.,</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Md. (State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12-28-65</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Dec. 31, 1965</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Park Highland Park Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR <b>Henry S. Washington &amp; Sons - 4925 Reane Cr. NE</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 3 1966</b>		24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
16785 20169									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General					d. STREET ADDRESS 6221 Kenilworth Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alfred J. Bullard			4. DATE OF DEATH Dec. 4 1965						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 79		9. AGE (In years last birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Accountant			10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) Kansas			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Bullard					14. MOTHER'S MAIDEN NAME Anna H. Jessup				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 214 52 6509		17. INFORMANT Address Marion P. Baillie Same as #2 (daughter)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 466x Multiple Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Phlebotrombosis of the lower extremities DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brouderence INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 23, 1965, to Dec. 4, 1965, that (I) (we) last saw the deceased alive on Dec. 4, 1965 and that death occurred at 9:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Dr. Aaron Deitz					22b. DATE SIGNED 6 Nov. 1965		22c. PHYSICIAN'S NAME (Type)		
22d. ADDRESS Hyattsville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12/6/65		23c. NAME OF CEMETERY OR CREMATORY Hawkins Funeral Home		23d. LOCATION (City, town or county) (State) Sarasota, Florida			
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DEC 8 1965		25b. REGISTRAR'S SIGNATURE Charles Judge		

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16786

20170

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundle			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewater 02X-2		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5308 O Street, S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM		First Middle Last JAMES BURKE		4. DATE OF DEATH December 3, 1965		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1881	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) St. Nicholas, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick Burke				14. MOTHER'S MAIDEN NAME Bridgett Sheehan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Thos. W. Burke - #1d above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Chronic Myocarditis (b) Arteriosclerotic Heart Disease (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 27, 1949, to Dec 3, 1965, that (I) (we) last saw the deceased alive on Dec 1, 1965, and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE James C. Cawood				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/3/65	
22c. PHYSICIAN'S NAME (Type) James C. Cawood				22d. ADDRESS 2520 Pa Ave S.E. Washington DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/6/65		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Jas. T. Ryan, Inc.				ADDRESS 317 Pa. Ave., SE DC3		25a. REC'D BY REGISTRAR DEC 7 1965	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



20130

CERTIFICATE OF DEATH

18330

Dec 1983

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

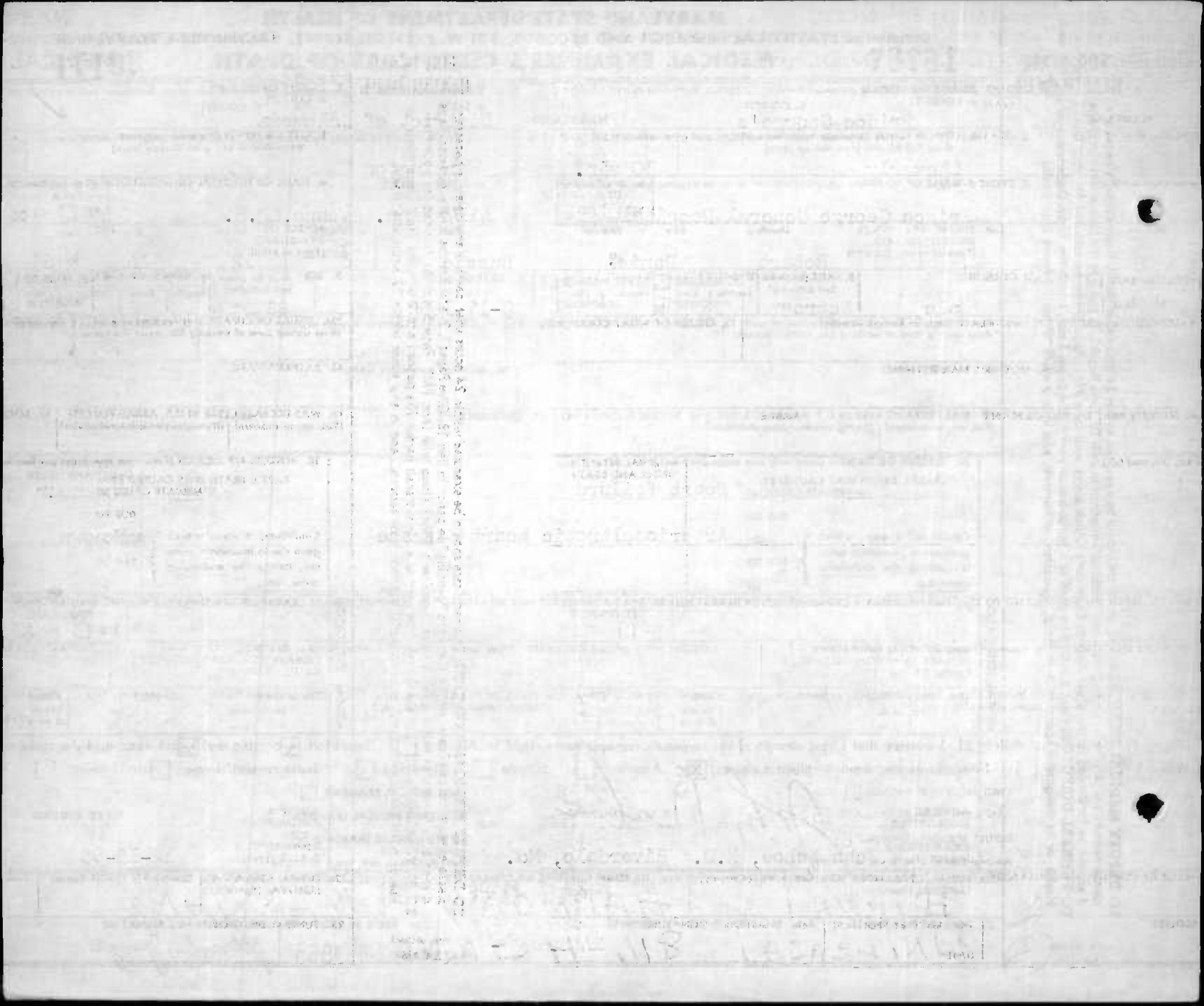
## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16787

20171

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>4117 Minn. Avenue, N.E.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		e. LENGTH OF STAY in 1b <b>30 min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Daniel Bussie</b>		4. DATE OF DEATH Month <b>12</b> Day <b>14</b> Year <b>19 65</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-1882</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>14</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b> <b>unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12-15-65</b>			
ACTUAL SIGNATURE <b>John Kehoe, M.D. Riverdale, Md.</b> EXAMINER'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>		<b>HARMONY</b>	<b>MARYLAND</b>
23. FUNERAL DIRECTOR <b>UNIVERSAL</b>		24a. REC'D BY REGISTRAR <b>816-H ST. N. DEC 20 1965</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

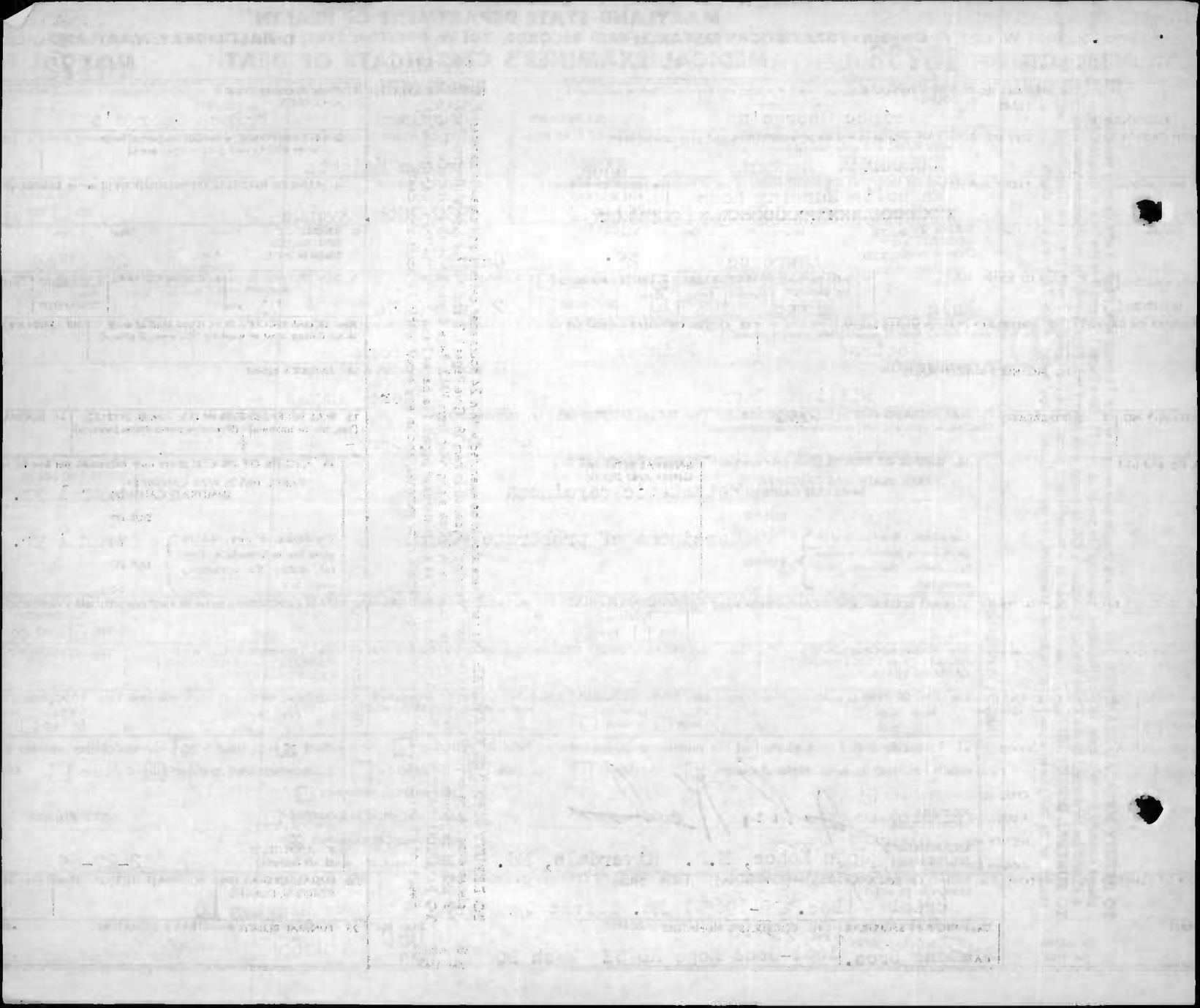


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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/63

<div> <div>16788</div> <div> <div>20172</div> </div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div> </div>												<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> c. LENGTH OF STAY IN lb <u>XXX</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Magnolia Nursing Home</u> <u>Prince George's General Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Marlowe Heights</u> d. STREET ADDRESS <u>5930 28th. Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Lawrence F. Carr</u>			<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>26</u> Year <u>1965</u>			<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>22 June 1894</u> <b>9. AGE</b> (In years last birthday) <u>71</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>																	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Painter</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>New York</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>  </u>				<b>13. FATHER'S NAME</b> <u>William Carr</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Nota Hayes</u>																			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> <b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. ENFORMANT</b> <u>Leonard R. Carr-</u> Address <u>Same as Item #2</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of prostate gland</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <u>  </u> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>  </u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> Hour e.m. <u>  </u> p.m. <u>  </u> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State) <u>  </u>																			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <u>John Kehoe</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME</b> (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>12-27-65</u>																							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>Dec. 29-1965</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet Cemetery</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>Washington DC</u>				<b>23. FUNERAL DIRECTOR</b> <u>Simmons Bros.</u> <b>ADDRESS</b> <u>1661-Good Hope RD SE Wash DC</u> <b>24a. REC'D BY REGISTRAR</b> <u>DEC 28 1965</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>																			



FOR STATE  
HEALTH DEPT. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
350D 4-64

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16789

20173

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 7506 Oxon Hill Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			
3. NAME OF DECEASED (Type or print) First Middle Last Guy W. S. Castle JR.		4. DATE OF DEATH Month 12 Day 5 Year 19 65	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 March 1915
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) White Historian Self employed		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Guy W. S. Castle Sr.	
14. MOTHER'S MAIDEN NAME Harriet Bayne		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.II	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Harriet B. Castle Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus 4201 DUE TO (b) From coronary artery occlusion DUE TO (c) From Arteriosclerotic heart disease unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 12-6-65	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-8-65	23c. NAME OF CEMETERY OR CREMATORY St. Barnabas Em.	23d. LOCATION (City, town or county) (State) Oxon Hill Md.
24. FUNERAL DIRECTOR W. W. Chambers & Son, 517-11th St. S.E.		25a. REC'D BY REGISTRAR DEC 9 1965	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



30173

ANNUAL REPORT OF THE

1960

THE STATE

OF NEW YORK

DEC 1 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 hr. 16 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> d. STREET ADDRESS <b>1711 Montgomery Road</b>				<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Twin A Baby</b> First <b>Boy</b> Middle <b>Chase</b> Last <b>Chase</b>				<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>24</b> Year <b>19 65</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>December 24, 1965</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>3</b>		<b>IF UNDER 1 YEAR</b> Months <b>16</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>--</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>--</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Prince George's, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>William Oliver Chase</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Marilyn Ruth Silva</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Bilateral atelectasis</b> <b>(b)</b> <b>Prematurity</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(c)</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Dec 24 / 1965</b> , <b>to</b> <b>Dec 24 / 1965</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Dec 24 / 1965</b> , <b>and that death occurred at</b> <b>6:39 M.</b> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <i>[Signature]</i>								<b>22b. DATE SIGNED</b> <b>12/24/65</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Irada Mandavi, M.D.</b>						<b>22d. ADDRESS</b> <b>6821 Riverdale Rd. Riverdale, Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>cremation</b>				<b>23b. DATE THEREOF</b> <b>1/8/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Prince Geo. Gen. Hosp.</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Cheverly, Maryland</b>			
<b>24. FUNERAL DIRECTOR</b> <b>William A. Parker</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JAN 12 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>			

2055

10100

HOWARD

LEWIS

Prince George's

ELIZABETH

13 yr. 10 mo.

CHERRY

1711 Montross Ave. Wash

Prince George's General Hospital

Chase Chase Boy Baby

December 24, 1943

White White

Prince George's, Maryland

Hamilton

William

*Handwritten signature*

NO 12/14/43

5521 Riverside Rd. Riverdale, Md.

Irma, Andrew, M.D.

CHERRY Prince Geo. Gen. Hosp. CHERRY, Maryland

JAN 12 1944

WILLIAM A. LLOYD, ASSISTANT ATTORNEY GENERAL

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16791 CERTIFICATE OF DEATH 20586									
Items #13 & 14 infor. taken from birth cert.									
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 hr. 40 min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge d. STREET ADDRESS 1711 Montgomery Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) "B" Baby First Middle Last Baby Boy Chase					4. DATE OF DEATH Month Day Year December 24 19 65				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 24, 1965		9. AGE (In years last birthday) yrs. Months Days 10 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Oliver Chase					14. MOTHER'S MAIDEN NAME Marilyn Ruth Silva				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --				16. SOCIAL SECURITY NO. --		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 Stenocarditis (Bilateral) (b) Prematurely (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Dec 24/65, 19 to Dec 24, 19 65, that (I) (we) last saw the deceased alive on Dec 24 / 19 65, and that death occurred at 6:40 PM, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE									
Iradj Mahdavi, M.D. 6821 Riverdale Rd. Riverdale, Md. cremation - 1/8/66 Prince Geo. Gen. Hosp. Cheverly, Maryland William A. Parker, Assist. Administrator JAN 12 1966 Charles Judge									

50588

1931

Howard

Living

Prince George's

Georgian

10 ft. 40 in.

XXI Montgomery Road

Prince George's General Hospital

December 24, 1931

Chase

Boy

Baby

John White

December 24, 1931

Prince George's, Maryland

Barry

William

*[Handwritten signature]*

*[Handwritten text]*

*[Faint handwritten text]*

*[Faint handwritten text]*

XXI

3331 Riverside Rd. Riverdale, Md.

Irish Memorial, N.D.

operation 1930 Prince Geo. Gen. Hosp. Barry, Maryland

JAN 12 1932

William A. Barker, M.D., Director



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16792

20174

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN ID <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>4003 Bunker Hill Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Augustine</b> Last <b>Chism</b>		4. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>1965</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Jan. 1898</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
13. FATHER'S NAME <b>Frederick Johnson Chism</b>		14. MOTHER'S MAIDEN NAME <b>Clara ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>579-14-6215A</b>	
17. INFORMANT <b>Lena Chism Same as #2 (wife)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right coronary artery occlusion</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>over 6 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <b>12-9-65</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/13/65</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 16 1965</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



100-100

100-100

(100-100)

100-100

100-100

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE					c. LENGTH OF STAY in 1b 11 DAYS								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL					e. STREET ADDRESS 1737 SUSQUEHANNOCK DRIVE								
3. NAME OF DECEASED (Type or print) JAMES EUGENE CHRISTENSEN					4. DATE OF DEATH DECEMBER 23 1965								
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 28 APRIL 1920		9. AGE (In years last birthday) 45 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER US AIR FORCE					10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE		11. BIRTHPLACE (County & State, or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES				
13. FATHER'S NAME JAMES CHRISTOPHER CHRISTENSEN					14. MOTHER'S MAIDEN NAME ANNA F. SORESENSEN								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					16. SOCIAL SECURITY NO. 1940 - 1965 482-09-2503		17. INFORMANT WIFE			Address SAME AS ITEM #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant melanoma 1909 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 12 Dec, 1965, to 23 Dec, 1965, that (I) (we) last saw the deceased alive on 23 Dec 1965, and that death occurred at 0500 PM, from the causes and on the date stated above.													
22a. SIGNATURE R G Pearce					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 23 Dec 65	
22c. PHYSICIAN NAME (Type) RONALD D PEARCE					22d. ADDRESS USAF HOSP, ANDREWS AIR FORCE BASE								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-27-65		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town or county) (State) Arlington, Virginia					
24. FUNERAL DIRECTOR W. W. Chambers & Co. 517-11th St. S.E.					25a. REC'D BY REGISTRAR DEC 28 1965		25b. REGISTRAR'S SIGNATURE Charles Judge						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16794

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20176

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly d. STREET ADDRESS 6417 Landover Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Guy M Clark 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor 10b. KIND OF BUSINESS OR INDUSTRY Railway Co		4. DATE OF DEATH Month Day Year Dec., 15 = 1965 8. DATE OF BIRTH 29 May 1895 9. AGE (In years last birthday) 70 yrs. 11. BIRTHPLACE (County & State, or foreign country) Maine 12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Omar Clark 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 17. INFORMANT Address Hospital records Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE a. <i>Crowning thrombosis, acute</i> 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, b. <i>Pulmonary embolism, acute</i> DUE TO c. <i>Empyema of lungs advanced</i>		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 24 hrs 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I (this hospital) attended the deceased from 12/8, 1965 to 12/15, 1965 that I (we) last saw the deceased alive on 12/15, 1965 and that death occurred at 6:20 AM from the causes and on the date stated above.			
22a. SIGNATURE Norman D. Gmean 22c. PHYSICIAN'S NAME (Type) Norman D. Gmean 22d. ADDRESS 3503 Penny St Mt Rainier		22b. DATE SIGNED 12/15/65 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Dec 17, 1965 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery 23d. LOCATION (City, town or county) Colmar Manor, Md. (State)		25a. REC'D BY REGISTRAR DEC 20 1965 25b. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.			

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OFFICE OF THE SECRETARY

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James Earl Ray

Memphis, Tennessee

James Earl Ray

Memphis, Tennessee

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James Earl Ray, Defendant

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 474.3		d. STREET ADDRESS 1814 29th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stephen		First Charles		Middle Clark		Last		4. DATE OF DEATH December 16 19 65		Month December		Day 16		Year 19 65	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 3, 1965		9. AGE (In years last birthday) yrs. 15		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Clark		14. MOTHER'S MAIDEN NAME Carol Oden		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT Charles Clark father same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline Membrane Disease 7735 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (c) DUE TO												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 12/3, 19 65, to 12/16, 19 65, that (I) (we) last saw the deceased alive on 12/16, 19 65, and that death occurred at 2:10 AM, from the causes and on the date stated above.															
22a. SIGNATURE Max M. Herzberg		22b. DATE SIGNED 12/17/65		22c. PHYSICIAN'S NAME (Type) Max M. Herzberg		22d. ADDRESS 7016 Greig St. Seat Pleasant, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-18-65		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.									
24. FUNERAL DIRECTOR See Funeral Home		25a. REC'D BY REGISTRAR DEC 22 1965		25b. REGISTRAR'S SIGNATURE Charles Judge											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16796 CERTIFICATE OF DEATH 20178									
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> d. STREET ADDRESS <u>Box 4217</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>James</u> Middle <u>H</u> Last <u>Coates</u>					4. DATE OF DEATH <u>December 2 1965</u> Month <u>December</u> Day <u>2</u> Year <u>1965</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26, 1927</u>		9. AGE (In years last birthday) <u>38</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Coates</u>					14. MOTHER'S MAIDEN NAME <u>Grace Smith</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>216 22 0323</u>		17. INFORMANT <u>Evelyn Coates</u> Address <u>Upper Marlboro, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction (left temporal lobe)</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis (left anterior cerebral artery)</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 30</u> , 1965, to <u>Dec. 2</u> , 1965, that (I) (we) last saw the deceased alive on <u>Dec. 2</u> , 1965, and that death occurred at <u>11:00</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Carolina Paredes Manlapaz, M.D.</u>					22b. DATE SIGNED <u>12-3-65</u>				
22c. PHYSICIAN'S NAME (Type) <u>Carolina Paredes Manlapaz, MD.</u>					22d. ADDRESS <u>Prince George's Genl. Hosp. Cheverly, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12-7-65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Croome Md.</u>			
24. FUNERAL DIRECTOR <u>W. Lewis 4339 New York Ave.</u>					25a. REC'D BY REGISTRAR <u>DEC 7 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATION

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VR A15 (4)  
20M 1/65

16797

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20179

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>15 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hyattsville Nursing Home Rpts Rd</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> <u>15 X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Corrado</u>		d. STREET ADDRESS <u>6526 Western Ave</u>	
4. DATE OF DEATH Month <u>Dec</u> Day <u>21</u> Year <u>1965</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1981</u> 84 yrs.	
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Providence town, Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Manuel Cook</u>		14. MOTHER'S MAIDEN NAME <u>Gloria Perry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-01-4883</u>	
17. INFORMANT <u>Elizabeth Amerikan</u>		Address <u>6526 Western Ave, Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia &amp; renal dropping</u> (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 MO.</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis</u> <u>Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>Dec.</u> , 19 <u>65</u> that (I) (we) last saw the deceased alive on <u>7-14</u> , 19 <u>65</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Lester S. Blumenthal</u>		22b. DATE SIGNED <u>12-21-65</u>	
22c. PHYSICIAN'S NAME (Type) <u>LESTER S. BLUMENTHAL</u>		22d. ADDRESS <u>5315 CONN. AVE NW WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-23-1965</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Fowler Inc</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1965</u>	
ADDRESS <u>5130 Wisc. Ave. NW. Wash, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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OFFICE OF THE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
20180											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>				c. LENGTH OF STAY IN 1b <u>10 MOS.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3405 LORRING DRIVE</u>						d. STREET ADDRESS <u>3405-LORRING DRIVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>A</u> Last <u>CREAMER</u>						4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>17</u> Year <u>1965</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 9, 1896</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
										IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - CLERK. U. S. CENSUS BUREAU</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MIDLAND, MD.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>			
13. FATHER'S NAME <u>RICHARD JOSEPH CREAMER</u>						14. MOTHER'S MAIDEN NAME <u>ROSE ANNE McVEIGH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>ROSHAEEN B. SAN FELLIPO - #2 above</u> Address <u>-</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>410X</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tumor of left kidney</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>19.50</u> to <u>12.00</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>16 Dec</u> 19 <u>65</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Warren B. Burch</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>WARREN B BURCH</u>						22d. ADDRESS <u>405 A St S.E. Wash 3 D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>12/20/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		23d. LOCATION (City, town or county) (State) <u>SUITLAND, MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>JAS. T. RYAN, INC.</u>						ADDRESS <u>317 PA. AVE S.E. DC</u>		25a. REC'D BY REGISTRAR <u>DEC 20 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16799											
20181											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) DISTRICT OF COLUMBIA						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON						
c. LENGTH OF STAY IN 1b 1hr 57min					d. STREET ADDRESS 4740 BENNING RD SE						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle RHONDA DENISE CROCHERON					4. DATE OF DEATH Month Day Year Dec 16 19 65						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Dec 1965		9. AGE (In years last birthday) yrs. Months Days 1 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) n/a					10b. KIND OF BUSINESS OR INDUSTRY n/a		11. BIRTHPLACE (County & State, or foreign country) Prince George's Md		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME RONALD CROCHERON					14. MOTHER'S MAIDEN NAME JOYCE W SINGLETARY						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. None		17. INFORMANT FATHER			Address SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c) OUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs 57 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Dec 16, 19 65 to Dec 16, 19 65, that (I) (we) last saw the deceased alive on Dec 16, 19 65, and that death occurred at 7:20 PM, from the causes and on the date stated above.											
22a. SIGNATURE Philip Steiner					M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec 16, 1965				
22c. PHYSICIAN'S NAME (Type) PHILIP STEINER, CAPT, USAF, MC					22d. ADDRESS USAF HOSP, ANDREWS AFB, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-21-65		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town or county) (State) Arlington Virginia			
24. FUNERAL DIRECTOR W. W. Chambers & Inc. 512-11th					25a. REC'D BY REGISTRAR H. A. E. DEC 27 1965		25b. REGISTRAR'S SIGNATURE Charles Judge				

5-160385

10181

DEPARTMENT OF COMMERCE

WALTON GEORGE

U.S. AIR FORCE BASE 11-33MIA WASHINGTON

U.S. HOSPITAL ANDREW'S 27

WASHINGTON

THOMAS BENTLEY

JOHN W. BENTLEY

JUNE 15 1952

NO

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JUN 15 1952  
U.S. AIR FORCE BASE 11-33MIA WASHINGTON  
U.S. HOSPITAL ANDREW'S 27  
WASHINGTON  
THOMAS BENTLEY  
JOHN W. BENTLEY  
JUNE 15 1952  
NO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Hgths</b>		c. LENGTH OF STAY IN 1b <b>16800</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>Prince George</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Hgths</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS <b>2345. Kenton Pl</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Robert H. Croggon</b>		First <b>Robert</b>		Middle <b>H.</b>		Last <b>Croggon</b>		4. DATE OF DEATH Month <b>12</b>		Day <b>15</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7.8.1892</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi</b>		11. BIRTHPLACE (County & State, or foreign country) <b>D C.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Henry Croggon</b>						14. MOTHER'S MAIDEN NAME <b>Catherine Chase</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579.22.5036</b>		17. INFORMANT <b>Maude E. Croggon</b>		Address <b>2345. Kenton Pl</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac. Myocardial Failure</b> 442x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>C. U. R. Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Larynx</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> , 19 <b>12-15</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12-14</b> , 19 <b>65</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Bernard Katzev</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-15-65</b>			
22c. PHYSICIAN'S NAME (Type) <b>BERNARD KATZEV M.D.</b>						22d. ADDRESS <b>2645 New York Ave. N.E.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12.18.65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington D C</b>					
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>						ADDRESS <b>300.4th st N E</b>		25a. REC'D BY REGISTRAR <b>DEC 20 1965</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

20183

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL MANOR 4922 LA SALLE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>DC</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1000 OTIS STREET N.E.</u> d. STREET ADDRESS <u>47X-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>FRANK BERNARD CURRAN</u>		<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>22</u> Year <u>1965</u>		<b>5. SEX</b> <u>M</u>			
<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3-15-1890</u>			
<b>9. AGE</b> (in years last birth - y) <u>75</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HIGHWAY ENGINEER</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MISSOURI</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>JAMES CURRAN</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY AGNES BRADY</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u> (If yes give year or dates of service) <u>WORLD WAR II</u>		<b>16. SOCIAL SECURITY NO.</b> <u>577-66-3984</u>		<b>17. INFORMANT</b> <u>Mary E. Cardillo</u> Address <u>105 Montrose Ave. Catonsville, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO <u>1533</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of sigmoid colon</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/16</u> , 19 <u>65</u> , <b>to</b> <u>12/22</u> , 19 <u>65</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12/22</u> , 19 <u>65</u> , <b>and that death occurred at</b> <u>8:00</u> M., <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>John W Winkler Jr</u>		<b>22b. DATE SIGNED</b> <u>12/22/65</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>John W Winkler Jr</u>			
<b>22d. ADDRESS</b> <u>5800 10th St Hyattsville Md.</u>		<b>22e. REC'D BY REGISTRAR</b> <u>Charles Judge</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12-27-65</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cem.</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Arlington</u>		<b>(State)</b> <u>Va.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis Collins 3821-14th St. N.W. Wash. D.C.</u>			
<b>25a. REC'D BY REGISTRAR</b> <u>DEC 28 1965</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

16802

20184

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5807 Maryhurst Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Evelyn</u>		First <u>K.</u> Middle <u>Damuth</u> Last		<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>17</u> Year <u>1965</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>October 11, 1881</u>		<b>9. AGE</b> (In years last birthday) <u>84</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>? Brittingham</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMY OR FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Donald Damuth</u> Address <u>Hyattsville</u> <u>5807 Maryhurst Drive</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4201 DUE TO (b) <u>ASCD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>several years</u>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12-6, 1965</u> <b>to</b> <u>12-17, 1965</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12-17, 1965</u> <b>and that death occurred at</b> <u>12:35</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Paul Angus Devore</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> PM MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>Dec. 17, 1965</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Paul Angus Devore, M.D.</u>				<b>22d. ADDRESS</b> <u>3415 Hamilton St. W. Hyattsville, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/20/65</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Baltimore</u> (State) <u>Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 20 1965</u>					
<b>24. FUNERAL DIRECTOR</b> <u>John A. Moran, Inc. 3000 E. Balto. St. Balto.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16803

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20185

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>West Hyattsville</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b>		d. STREET ADDRESS <b>5622 31st Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle <b>B.</b> Last <b>Davey</b>		4. DATE OF DEATH Month <b>December</b> Day <b>19</b> Year <b>1965</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1883</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clifton (last name) Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>4904 Edgewood Rd. College Park, Md.</b>	
17. INFORMANT <b>Raymond Davey</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC H.T. DISEASE</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>MIN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John N Kehoe</b> M.D. EXAMINER'S NAME (Type) <b>JOHN N KEHOE</b>		22. DATE SIGNED <b>12-20-65</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/22/65</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's</b>		ADDRESS <b>Mt. Rainier Maryland</b>	
25a. REC'D BY REGISTRAR <b>DEC 28 1965</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

20182

MINNESOTA DEPARTMENT OF REVENUE

15804

State of Minnesota

Department of Revenue

October 1, 1918

Madam

Dear Sir:

X

Enclosed

enclosed

is a check

for \$100.00

to

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

16804

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20186

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>8 mos., 28 dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>2526 14th St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Leona B. Davis</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>20</b> Year <b>19 65</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/1/1897</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFIRMARY <b>Record Room</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>bronchopneumonia</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis with arterio-</b> (c) <b>sclerotic heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic pyelonephritis; recurrent cerebrovascular accidents</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> <b>8:30 P.</b> to <b>12/20</b> , 1965, that (I) (we) last saw the deceased alive on <b>12/20</b> <b>1965</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Moe Weiss</b>				22b. DATE SIGNED <b>12/20/65</b>		22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>	
22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>12-23-65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmon M. R. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Md.</b>	
24. FUNERAL DIRECTOR <b>Universal Home 816 H. St. N.E.</b>				25a. REC'D BY REGISTRAR <b>DEC 27 1965</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION



Prison Camp

Glenn Dale (Camp)

Glenn Dale Hospital

John

B.

Davis

Dec.

Female

Neuro

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1917

Latent

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unknown

USA

unknown

unknown

U. S. General Hospital  
Washington, D. C.

unknown

Glenn Dale

Glenn Dale Hospital

2 weeks

Generalized convulsions with  
colic, heart disease

unknown

Chronic pyelonephritis; recurrent cataplexy and  
paroxysms

12/10

12/10

12/10

12/10/17

Glenn Dale Hospital  
Glenn Dale, Maryland

The White, H. D.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)  
5M 1/65

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16805

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item #8 & 9 Film #8371 12/13/65 re

20187

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>MARIE</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>1</b> Year <b>19 65</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/23/1889</b> <b>Sept 21, 1898</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander F. Dougaree</b>		14. MOTHER'S MAIDEN NAME <b>Clara Reeder</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217 14 7358B</b>	
17. INFORMANT <b>Roland J. Davis</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) <b>Arteriosclerotic heart disease</b> OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple myeloma - unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>12/1/65</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M. D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/3/65</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 6 1965</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16806

20188

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS 3522 54th Avenue Apt #1	
3. NAME OF DECEASED (Type or print) First Middle Last CORNELIUS PAUL DeBruyn Sr.		4. DATE OF DEATH Month Day Year Dec. 2, 19 65	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1900
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glazier		10b. KIND OF BUSINESS OR INDUSTRY Automobile Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cornelius P. DeBruyn		14. MOTHER'S MAIDEN NAME Mary A. Cortwright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578 03 5165	
17. INFORMANT Emma F. DeBruyn Same as #2 (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH minutes over 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 12/3/65	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/4/65	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City, town or county) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 6 1965	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the deputy medical examiner should execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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EXAMINER'S CERTIFICATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16807

20189

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5511 Alice Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Kenneth Last Deitz		4. DATE OF DEATH Month December Day 18 Year 1965					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/43	9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Deitz				14. MOTHER'S MAIDEN NAME Jean Merkle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Harvey Deitz, Hyndman, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral (Infectious) Hepatitis 092X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/13/65, 19 65 to 12/18, 19 65, that (I) (we) last saw the deceased alive on Dec. 18, 19 65, and that death occurred at 1:30M, from the causes and on the date stated above.							
22a. SIGNATURE C. Louis Mendel, M. D.				22b. DATE SIGNED 12/18/65		22c. PHYSICIAN'S NAME (Type) C. Louis Mendel, M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/ 20/65		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		23d. LOCATION (City, town or county) (State) Hyndman, Pa.	
24. FUNERAL DIRECTOR F. Gaxch's Sons 4739 Balt. Ave, Hyattsville				25a. REC'D BY REGISTRAR DEC 22 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16808

20190

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6119 43rd Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Prince George</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> d. STREET ADDRESS <u>6119 43rd Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lillie</u> Middle <u>M.</u> Last <u>Denekas</u>		<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>14</u> Year <u>1965</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 17, 1906</u>		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired - Secretary</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hospital</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington D. C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Anthony Denekas</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lillie Kuhn</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>Lillian Hopkins</u>		Address <u>3818-A W Street, S. E.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca Sigmoid Colon</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Feb 1964</u> <u>1960</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic Heart Dis.</u>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11/17</u> <u>1965</u> , to <u>12/14</u> <u>1965</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>12/17</u> <u>1965</u> , and that death occurred at <u>10:10</u> <u>AM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Rose S. Williams</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12/14/65</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ROGER S. WILLIAMS</u>		<b>22d. ADDRESS</b> <u>35 NEW YORK AVE NW</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>12-17-65</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington D. C.</u>		<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wilhelm Funeral Home</u>		<b>ADDRESS</b> <u>4308 Suitland Rd Suitland Maryland</u>	
<b>25a. REC'D BY REGISTRAR</b> <u>DEC 17 1965</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>									

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <u>Brentwood</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> c. LENGTH OF STAY IN 1b <u>75 years</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland,</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X</u> d. STREET ADDRESS <u>4522 1/2 41st. Ave.</u>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Rebecca</u> <u>Dent</u> First Middle Last					<b>4. DATE OF DEATH</b> <u>December 6,</u> <u>1965</u> Month Day Year				
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11-27-1882</u>		<b>9. AGE</b> (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Charlestown, West Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Matilda Wright</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>218-30-3667</u>		<b>17. INFORMANT</b> <u>Mrs. Lucille Quarles</u>		<b>Address</b> <u>4522 - 41st. Ave.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia</u> (b) <u>Arteriosclerosis</u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 mos</u> <u>3 yrs</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>  </u> <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12-4</u> , 19 <u>65</u> , <b>to</b> <u>12-6</u> , 19 <u>65</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12-4</u> , 19 <u>65</u> , <b>and that death occurred at</b> <u>6 PM</u> , <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Leonard Hays</u>								<b>22b. DATE SIGNED</b> <u>12-6-65</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Leonard Hays</u>					<b>22d. ADDRESS</b> <u>5201 Bal. Ave. Hyattsville Md.</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>12-11-1965</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Harmony Mem. Park</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>7601 - Sheriff Road, Md.</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Washington Funeral Chapel</u>					<b>ADDRESS</b> <u>475 H. St. N. W.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 13 1965</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16810 CERTIFICATE OF DEATH 20192

1. PLACE OF DEATH a. CDUNITY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi c. LENGTH OF STAY IN 1b 20 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Saint George's Nursing Home			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE DC b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3 d. STREET ADDRESS 5121-4th St. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Rose L. WICKEN 4. DATE OF DEATH Month Day Year 12-26 1965			5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 2 1886 9. AGE (in years last birthday) 79 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (County & State, or foreign country) RUSSIA 12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME UNKNOWN 14. MOTHER'S MAIDEN NAME UNKNOWN			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT WM. DICKEN (see 20a)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 cardiovascular collapse DUE TO (b) carcinoma of the Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) carcinoma of the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 6 mos.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from July 26, 1965 to 12-26, 1965, that (I) (we) last saw the deceased alive on 12-21 1965, and that death occurred at 9:55M from the causes and on the date stated above.			22a. SIGNATURE Arthur G. Willets 22b. DATE SIGNED 12-26-65 22c. PHYSICIAN'S NAME (Type) ARTHUR G. WILLETS 22d. ADDRESS 1015 SPRING ST. SSPG MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 12/28/65 23c. NAME OF CEMETERY OR CREMATORY NATL. MEM. PARK 23d. LOCATION (City, town or county) (State) FALLS CHURCH, VA.			24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR DEC 29 1965 25b. REGISTRAR'S SIGNATURE Charles Judge		



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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16811

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20193

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andrews Air Force Base Hospital</u>			d. STREET ADDRESS <u>7702 Morris Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>(NONE)</u> Last <u>Dobrowski</u>			4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1965</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 Jan. 1913</u>		9. AGE (In years last birthday) <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nav. Com. Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.F.</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
13. FATHER'S NAME <u>Joseph Dobrowski</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Ret. 1963</u>		16. SOCIAL SECURITY NO. <u>267-52-3505</u>		17. INFORMANT Address <u>Hilda M. Dobrowski Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: <u>5810</u> IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>From Aspiration of vomitus (blood)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and Rupture of oesophageal varices</u> DUE TO <u>From portal hypertension</u> (c) <u>From cirrhosis of liver.</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>12-31-65</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-3-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers G. Inc.</u>		ADDRESS <u>515-11 E.A. &amp; E.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		DATE <u>JAN 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10191

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16812  
CERTIFICATE OF DEATH

20194

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5519 NICHOLSON ST. APT 202</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b> d. STREET ADDRESS <b>5519 NICHOLSON ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>DANIEL</b> First <b>A</b> Middle <b>DONOHUE</b> Last			4. DATE OF DEATH <b>DEC</b> Month <b>22</b> Day <b>1965</b> Year		
5. SEX <b>MALE</b>			6. COLOR OR RACE <b>CAUCASIAN</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>SEPT 10, 1886</b>		
9. AGE (In years last birthday) <b>79</b> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>JAMES DONOHUE</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET FEEHAN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>578-163465</b>		
17. INFORMANT <b>EDITH E. DONOHUE</b> Address <b>SAME AS #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Chronic Cardiac Vascular</b> <b>nephros - Sclerotic</b> (c) DUE TO <b>24 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>7:00</b> p.m. <b>12:00</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>15 Sept 65</b>			20f. (City or town) (County) (State) <b>27 Ave 65</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>15 Sept 1965</b> to <b>27 Dec 65</b> , that (I) (we) last saw the deceased alive on <b>22 Dec 1965</b> , and that death occurred at <b>7:00</b> P.M. from the causes and on the date stated above.					
22a. SIGNATURE <b>Robert C. Haile</b>			22b. DATE SIGNED <b>12/23/65</b>		
22c. PHYSICIAN'S NAME (Type) <b>ROBERT C. HAILE</b>			22d. ADDRESS <b>35 NEW YORK AVE. N.W. D.C.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12-27-1965</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>			23d. LOCATION (City, town or county) (State) <b>BLADENSBURG, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md.</b>			25a. REC'D BY REGISTRAR <b>DEC 28 1965</b>		
			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

1913

1913

1913

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME  
5M 1/63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> d. STREET ADDRESS <u>3818 Allison Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
<b>3. NAME OF DECEASED</b> (Type or print) <u>Maxime L DuCharme</u>			<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>19</u> Year <u>1965</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>31 July 1906</u> <b>9. AGE</b> (in years last birthday) <u>59</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Yellow Cab Co.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Glasgow, Scotland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>										
<b>13. FATHER'S NAME</b> <u>Maxime L. DuCharme</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Stewart</u>												
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mrs. Evelyn M. DuCharme (above address)</u> Address <div style="text-align: right;">(Wife)</div>												
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> <u>976x</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>minutes</u>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head.</u>														
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>5:00pm.</u> <u>12-19-1965</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Same as #2</u> (County) (State)										
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <u>John Kehoe</u> <b>EXAMINER'S NAME</b> (Type) <u>John Kehoe, M.D.</u>					<b>DATE SIGNED</b> <u>12-20-65</u>												
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>22b. DATE THEREOF</b> <u>12/22/65</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>National Memorial Park</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Falls Church, Va.</u> (State)										
<b>23. FUNERAL DIRECTOR</b> <u>Nailey's Funeral Home</u> ADDRESS <u>Maryland</u>					<b>24a. REC'D BY REGISTRAR</b> <u>DEC 28 1965</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>										





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16814

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20196

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmonston</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>4920 49th. Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Andro Max Dunaev</u>		4. DATE OF DEATH Month Day Year <u>12 31 19 65</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 Oct. 1897</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi Cab</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Maxim Dunaev</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579 01 6163</u>	
17. INFORMANT <u>Helen P. Dunaev</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic heart disease</u> over 10 yrs. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>12-31-65</u>	
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Washington Memo.</u>		23d. LOCATION (City or Town) (County) (State) <u>Hyattsville Maryland</u>	
24. FUNERAL DIRECTOR <u>J. Wm. Lees Sons, Washington, DC</u>		25a. REC'D BY REGISTRAR <u>JAN 5 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

88105

STATE OF TEXAS

1905

1905

County of ... State of Texas

Know all men by these presents, that ...

For and in consideration of the sum of ... Dollars, to ... in hand paid by ... the receipt of which is hereby acknowledged, the said ... do hereby certify that ...

Witness my hand and seal of office this ... day of ... 1905.

Notary Public in and for the State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M -1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>33 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Mt. Rainier</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						d. STREET ADDRESS <b>4308 Russell Avenue</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank E. Dunklee</b>						4. DATE OF DEATH Month Day Year <b>December 29 1965</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1899</b>		9. AGE (In years last birthday) <b>66 65 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sightseeing Guide</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Newport, Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Dunklee</b>						14. MOTHER'S MAIDEN NAME <b>Nannie Williams</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>578-01-8311</b>		17. INFORMANT <b>Mrs. Sarah L. Dunklee (above address)</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Heart Disease</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gen. Arterio Sclerosis</b> DUE TO (c) <b>Penetrating Duodenal Ulcer</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Gastroechony</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/26</b> , 19 <b>65</b> , to <b>12/29</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12/29</b> 19 <b>65</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Zouheir Shama</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/29/65</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Zouheir Shama</b>						22d. ADDRESS <b>Prince Geo. General Hosp., Cheverly, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12/31/65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>			
24. FUNERAL DIRECTOR <b>Nalley's Home Inc.</b>						ADDRESS <b>Mt. Rainier, Maryland</b>		25a. REC'D BY REGISTRAR <b>IAN 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

[illegible]

1

Figure 1

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

16816

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20198

1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		e. LENGTH OF STAY in 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		d. STREET ADDRESS 7259 Booker Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarence William Edmunds				4. DATE OF DEATH Month Day Year 12 21 1965			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-26-1910	
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Minnie Edmunds Same as 2D			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Heart failure 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive cardio vascular disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-27-65				22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery 22d. LOCATION (City, town, or county) (State) Highland Park Md			
23. FUNERAL DIRECTOR H.S. Washington & Son 4925 Neane Ave NE				24a. REC'D BY REGISTRAR DEC 29 1965 24b. REGISTRAR'S SIGNATURE J Charles Judge			





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 20199

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		d. STREET ADDRESS 9111 Susan Lane	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Clinton Medical Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bernard Ernest Emmert				4. DATE OF DEATH Month Day Year 12 25 19 65			
5. SEX M W	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Jan., 1919	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Gas Light Company		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard Emmert				14. MOTHER'S MAIDEN NAME Lottie Fowler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Bernard E. Emmert, Jr 9111 Susan Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Minutes Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Kehoe, M.D., Riverdale				DATE SIGNED 12-25-65	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-65	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia		
23. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home		ADDRESS 308 Suitland Rd Suitland Md		24a. REC'D BY REGISTRAR DEC 30 1965		24b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

10000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION		9. RELIGION		10. RACE	
11. ADDRESS		12. CITY		13. STATE		14. ZIP CODE		15. COUNTY	
16. DATE OF DEATH		17. TIME OF DEATH		18. PLACE OF DEATH		19. CAUSE OF DEATH		20. MANNER OF DEATH	
21. SIGNATURE OF EXAMINER		22. SIGNATURE OF WITNESS		23. SIGNATURE OF DECEASED		24. SIGNATURE OF NEAREST RELATIVE		25. SIGNATURE OF CLERK	
26. SIGNATURE OF JUDGE		27. SIGNATURE OF SHERIFF		28. SIGNATURE OF CORONER		29. SIGNATURE OF PROSECUTOR		30. SIGNATURE OF DEFENSE ATTORNEY	
31. SIGNATURE OF JURY		32. SIGNATURE OF COURT		33. SIGNATURE OF JUDGE		34. SIGNATURE OF SHERIFF		35. SIGNATURE OF CORONER	
36. SIGNATURE OF PROSECUTOR		37. SIGNATURE OF DEFENSE ATTORNEY		38. SIGNATURE OF JURY		39. SIGNATURE OF COURT		40. SIGNATURE OF JUDGE	
41. SIGNATURE OF SHERIFF		42. SIGNATURE OF CORONER		43. SIGNATURE OF PROSECUTOR		44. SIGNATURE OF DEFENSE ATTORNEY		45. SIGNATURE OF JURY	
46. SIGNATURE OF COURT		47. SIGNATURE OF JUDGE		48. SIGNATURE OF SHERIFF		49. SIGNATURE OF CORONER		50. SIGNATURE OF PROSECUTOR	
51. SIGNATURE OF DEFENSE ATTORNEY		52. SIGNATURE OF JURY		53. SIGNATURE OF COURT		54. SIGNATURE OF JUDGE		55. SIGNATURE OF SHERIFF	
56. SIGNATURE OF CORONER		57. SIGNATURE OF PROSECUTOR		58. SIGNATURE OF DEFENSE ATTORNEY		59. SIGNATURE OF JURY		60. SIGNATURE OF COURT	
61. SIGNATURE OF JUDGE		62. SIGNATURE OF SHERIFF		63. SIGNATURE OF CORONER		64. SIGNATURE OF PROSECUTOR		65. SIGNATURE OF DEFENSE ATTORNEY	
66. SIGNATURE OF JURY		67. SIGNATURE OF COURT		68. SIGNATURE OF JUDGE		69. SIGNATURE OF SHERIFF		70. SIGNATURE OF CORONER	
71. SIGNATURE OF PROSECUTOR		72. SIGNATURE OF DEFENSE ATTORNEY		73. SIGNATURE OF JURY		74. SIGNATURE OF COURT		75. SIGNATURE OF JUDGE	
76. SIGNATURE OF SHERIFF		77. SIGNATURE OF CORONER		78. SIGNATURE OF PROSECUTOR		79. SIGNATURE OF DEFENSE ATTORNEY		80. SIGNATURE OF JURY	
81. SIGNATURE OF COURT		82. SIGNATURE OF JUDGE		83. SIGNATURE OF SHERIFF		84. SIGNATURE OF CORONER		85. SIGNATURE OF PROSECUTOR	
86. SIGNATURE OF DEFENSE ATTORNEY		87. SIGNATURE OF JURY		88. SIGNATURE OF COURT		89. SIGNATURE OF JUDGE		90. SIGNATURE OF SHERIFF	
91. SIGNATURE OF CORONER		92. SIGNATURE OF PROSECUTOR		93. SIGNATURE OF DEFENSE ATTORNEY		94. SIGNATURE OF JURY		95. SIGNATURE OF COURT	
96. SIGNATURE OF JUDGE		97. SIGNATURE OF SHERIFF		98. SIGNATURE OF CORONER		99. SIGNATURE OF PROSECUTOR		100. SIGNATURE OF DEFENSE ATTORNEY	

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16818

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20200

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>609 48th. Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George Henry Erskine</b>		4. DATE OF DEATH Month <b>12</b> Day <b>29</b> Year <b>19 65</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 May 1942</b>
9. AGE (In years last birthday) <b>23</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Post Office</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Erskine</b>		14. MOTHER'S MAIDEN NAME <b>Viola Simpson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Linda L. Erskine</b>		Address <b>609 48th Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>976 X</b> IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head.</b>	
20c. TIME OF INJURY Month, Day, Year <b>2:00pm p.m. 12-29- 1965</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bathroom</b>		20f. (City or town) (County) (State) <b>5749 Southern Ave., Capitol Heights, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>12-30-65</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-3-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		25a. REC'D BY REGISTRAR <b>AN 4</b>	
ADDRESS <b>4308 Suitland Rd Suitland Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

16819

20201

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>4411 Oliver Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>H</b> Last <b>Ewing</b>		4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>19 65</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1889</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Supt. Water Proofing Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>St. George, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Ewing</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Shaeffer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-01-5738</b>	
17. INFORMANT <b>Mary C. Ewing same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far Advanced Pulmonary Tuberculosis</b> 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia Rt. Lower Lobe</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 10</b> , 19 <b>65</b> , to <b>Dec. 15</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec. 15</b> , 19 <b>65</b> , and that death occurred at <b>12:20</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Rosa L. Barlin md.</b>		22b. DATE SIGNED <b>12-15-65</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Rosa L. Barlin</b>		22d. ADDRESS <b>Prince Geo. General Hosp., Cheverly, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>12/18/65</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Montgomery County, Md.</b>
24. FUNERAL DIRECTOR <b>The H. Hines Co. 2901 14th ST. N.W.</b>		25a. REC'D BY REGISTRAR <b>DEC 20 1965</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

16820		20202	
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b> d. STREET ADDRESS <b>BALTIMORE BLVD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS Wilbur F Faurot</b>		4. DATE OF DEATH Month Day Year <b>December 15 1965</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 15 1914</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUTCHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat</b>	9. AGE (In years last birthday) <b>51</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>WILBUR FAUROT</b>		14. MOTHER'S MAIDEN NAME <b>MADGE ONSTOTT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>262 03 9444</b>	
17. INFORMANT <b>MRS MADGE ONSTOTT FAUROT</b>		Address <b>RT 3 BOX 206 MARIANNA FLA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MENINGITIS</b> <b>491X</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>BRONCHOPNEUMONIA</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>ONE WEEK</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>14 DEC. 1965</b> , to <b>15 DEC. 1965</b> , that (I) (we) last saw the deceased alive on <b>15 DEC. 1965</b> , and that death occurred at <b>6:30 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>C. J. Houmann</b>		22b. DATE SIGNED <b>15 DEC. 65</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. J. HOUMANN</b>		22d. ADDRESS <b>RIVERDALE MD.</b>	
23a. BURIAL, CREMATION, REMOVE (Specify) <b>Buried</b>	23b. DATE THEREOF <b>12-17-65</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City, town or county) (State) <b>BLADENSBURG, MARYLAND</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale Md</b>		25a. REC'D BY REGISTRAR <b>DEC 21 1965</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16821

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

20203

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
c. LENGTH OF STAY IN 1b 1 day		d. STREET ADDRESS 4303 Kaywood Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			
3. NAME OF DECEASED (Type or print) First Middle Last Vincent T. Finn		4. DATE OF DEATH Month Day Year December 15 19 65	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3- 1898
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.		10b. KIND OF BUSINESS OR INDUSTRY Pepsi-Cola Co.	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John M. Finn	
14. MOTHER'S MAIDEN NAME Vola Stephens		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI	
16. SOCIAL SECURITY NO. 219-07-8643		17. INFORMANT Mrs. Evelyn K. Finn (above address) (Wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 4201 DUE TO Myocardial Infarction. (b) Coronary Occlusion (c) Arteriosclerotic Heart Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 65 to 12/15/65, that (I) (we) last saw the deceased alive on 11/16/65, and that death occurred at 11:15 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Leon Levitsky		22b. DATE SIGNED 12/16/65	
22c. PHYSICIAN'S NAME (Type) Dr. Leon Levitsky		22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/20/65	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	23d. LOCATION (City, town or county) (State) Arlington, Va.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Forestville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marian</u> Middle <u>Teresa</u> Last <u>Flaherty</u>		4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1965</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 June 1912</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Washington, DC.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas J. Pumphrey</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Sollars</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Bennard J. Flaherty</u>		Address <u>10126- Griff Drive S.E. Friendly, Maryland. 20022</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u>		22. DATE SIGNED <u>12-6-65</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>		Address (Street, city, town, or county) <u>Riverdale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 9-1965</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Simmons Brothers</u>		ADDRESS <u>1661- Good Hope Rd. S.E. Wash.</u>	
25a. REC'D BY REGISTRAR <u>DEC 7 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

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1. PLACE OF DEATH a. COUNTY <i>Pr George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6610 Gude Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>F</i> Last <i>Flippin</i>		4. DATE OF DEATH Month <i>dec</i> Day <i>8</i> Year <i>1965</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>dec 28 1889</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Superior</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Burgman Laundry</i>	
11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel Clark Flippin</i>		14. MOTHER'S MAIDEN NAME <i>Jessy Bell Hudson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>MD</i>	
17. INFORMANT <i>Mrs. Sandra Lewis</i>		Address <i>1301 Franklin Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic myocarditis with fatty decomp.</i> DUE TO (c) <i>Thrombotic phlebitis left leg.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>12/7/65</i> <i>10 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11/17/65</i> to <i>12/8/65</i> , that (I) (we) last saw the deceased alive on <i>12/7/65</i> , and that death occurred at <i>2</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard T Morse MD</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Howard T Morse</i>		22d. ADDRESS <i>7030 Carroll Ave Takoma Park Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 4-65</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Landover Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>252 Carroll Pl NW DC</i>	
25a. REC'D BY REGISTRAR <i>DEC 13 1965</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20207

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7608 Marlboro Pike	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrews Air Force Base Hospital		e. STREET ADDRESS Forestville	
3. NAME OF DECEASED (Type or print) Michael Andrew Folk		4. DATE OF DEATH 12 7 1965	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 July 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington, D. C.
13. FATHER'S NAME Richard James Folk		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard J. Folk		Address 7708 Marlboro Pike	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns 35% of body surface 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and Intoxication of carbon dioxide and carbon monoxide DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trapped in burning house.	
20c. TIME OF INJURY Month, Day, Year 10:50 p.m. 12-7- 1965	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Same as #2 (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 12-8-65	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-10-65	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City, town or county) Arlington Virginia
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland		25a. REC'D BY REGISTRAR DEC 13 1965 25b. REGISTRAR'S SIGNATURE J Charles Judge	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
35DD 4-64

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> <span style="float: right;">DOA</span> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andrews Air Force Base Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Prince George's</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u> d. STREET ADDRESS <u>7608 Marlboro Pike</u>				<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Richard James Folk Jr.</u>		<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>7</u> Year <u>1965</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>5 Oct. 1961</u>		<b>9. AGE (in years last birthday)</b> <u>4</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>  </u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Richard James Folk</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Eleanor Florence Walsh</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> <b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Richard J. Folk</u>		<b>Address</b> <u>7708 Marlboro Pike</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Intoxication of carbon dioxide and carbon monoxide</u> 9160 DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) <u>  </u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>  </u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Trapped in burning house</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>10:50 p.m. 12-7-1965</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town) (County) (State)</b> <u>Same as #2</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		<b>ACTUAL SIGNATURE</b> <u>John Kehoe, M.D.</u>		<b>22. DATE SIGNED</b> <u>12-8-65</u>		<b>EXAMINER'S NAME (Type)</b> <u>John Kehoe, M.D.</u> <u>Riverdale, Md.</u> <b>Address</b> (Street, city, town, or county) <u>  </u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12-10-65</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Arlington Virginia</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Wilhelm Funeral Home</u> <u>4308 Suitland Rd</u> <u>Suitland Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 13 1965</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

20305

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20305

MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with multiple paragraphs and possibly a signature block at the bottom.]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

16827

20209

<b>1. PLACE OF DEATH</b> a. COUNTY <p style="text-align: center;">Prince George's</p> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p style="text-align: center;">Cheverly</p> c. LENGTH OF STAY IN 1b <p style="text-align: center;">1 day</p> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <p style="text-align: center;">Prince George's General Hospital</p>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <p style="text-align: center;">Maryland</p> b. COUNTY <p style="text-align: center;">Prince George's</p> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p style="text-align: center;">X Takoma Park</p> d. STREET ADDRESS <p style="text-align: center;">1212 Myrtle Avenue</p> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) <p style="text-align: center;">Bertha V Fowler</p>		<b>4. DATE OF DEATH</b> Month Day Year <p style="text-align: center;">December 17 1965</p>		<b>5. SEX</b> Female		<b>6. COLOR OR RACE</b> White		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <p style="text-align: center;">April 18, 1882</p>		<b>9. AGE</b> (In years last birthday) 83 yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> own home		<b>11. BIRTHPLACE</b> (County & State, or foreign country) Prince Georges Md.		<b>12. CITIZEN OF WHAT COUNTRY?</b> U S A	
<b>13. FATHER'S NAME</b> <p style="text-align: center;">George G. Stewart</p>				<b>14. MOTHER'S MAIDEN NAME</b> <p style="text-align: center;">Emma Jane Binnix</p>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) no				<b>16. SOCIAL SECURITY NO.</b> 577 017 423A				<b>17. INFORMANT</b> Address Ethel Fowler Tokoma Park, Md.					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 491X DUE TO (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																		INTERVAL BETWEEN ONSET AND DEATH <p style="text-align: center;">2 hours</p>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)																		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <p style="text-align: center;">19</p>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/17</u> , 19 <u>65</u> , to <u>12/16</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/17</u> , 19 <u>65</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.																					
<b>22a. SIGNATURE</b> <p style="text-align: center;">Leon R. Levitsky</p>																		<b>22b. DATE SIGNED</b> <p style="text-align: center;">12/17/65</p>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <p style="text-align: center;">Leon R. Levitsky</p>																		<b>22d. ADDRESS</b> <p style="text-align: center;">3408 Rhode Island Ave. Mt. Rainier, Md.</p>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial				<b>23b. DATE THEREOF</b> <p style="text-align: center;">Dec 20, 1965</p>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <p style="text-align: center;">Cedar Hill Cemetery</p>				<b>23d. LOCATION</b> (City, town or county) (State) <p style="text-align: center;">Suitland, Md.</p>									
<b>24. FUNERAL DIRECTOR</b> <p style="text-align: center;">F. Ga sch's Sons Hyattsville, Md.</p>																		<b>25a. REC'D BY REGISTRAR</b> DATE <p style="text-align: center;">DEC 22 1965</p>		<b>25b. REGISTRAR'S SIGNATURE</b> <p style="text-align: center;">Charles Judge</p>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

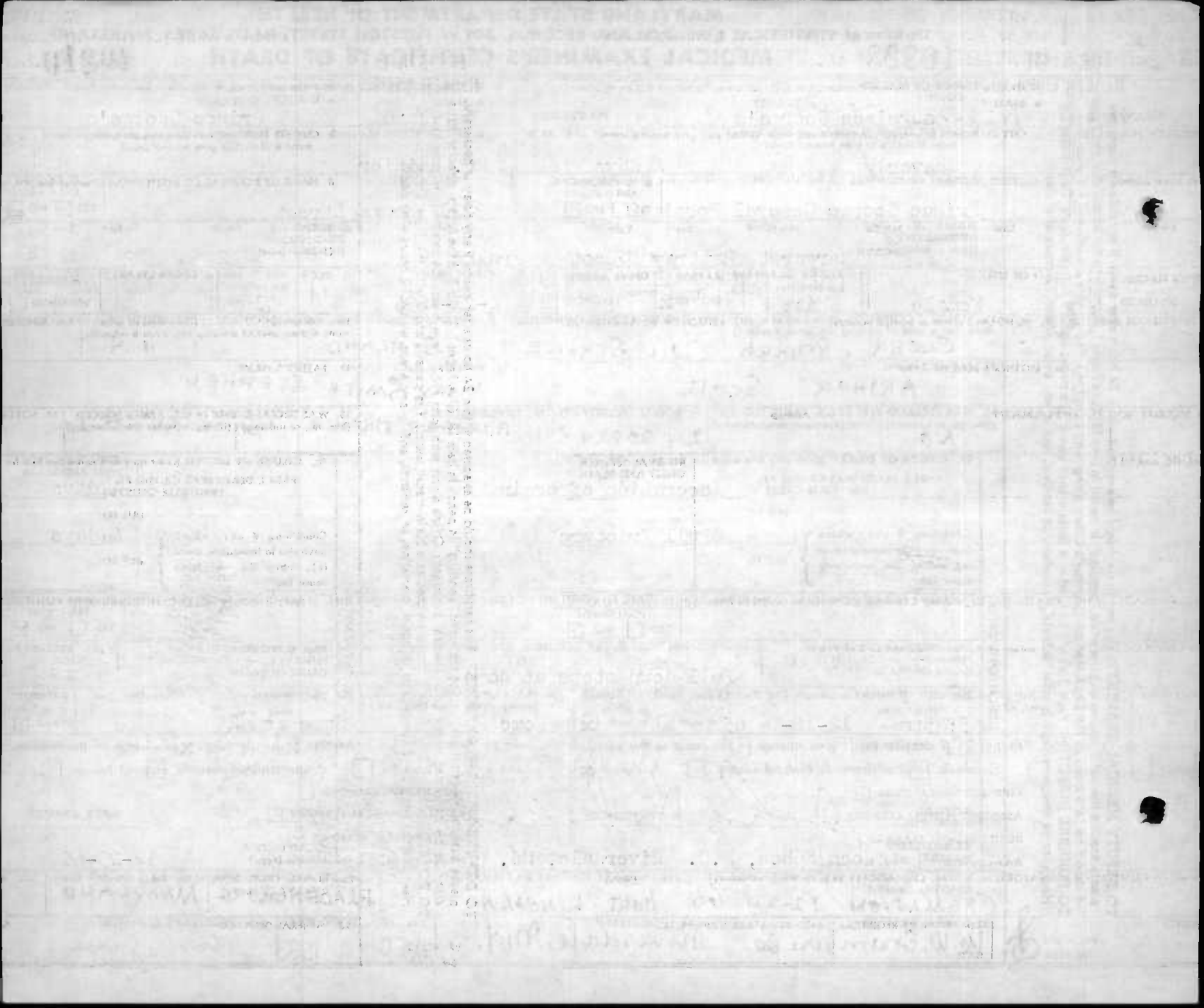
16828

STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20210

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Rattray Scot Fralic				4. DATE OF DEATH Month Day Year 12 22 19 65			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-21-1894	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK, RETIRED				10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE		11. BIRTHPLACE (State or foreign country) SCOTLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME ARTHUR SCOTT				14. MOTHER'S MAIDEN NAME MARY SMITH STEPHEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214 207248		17. INFORMANT W. BURCHER BROWN Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 9000 DUE TO Conditions, if any, which gave rise to immediate cause (b) Skull fracture (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps at home 20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:45 p.m. 12-18-19 65 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Same as #2 (County) (State)							INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-23-65			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 12-24-65		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		22d. LOCATION (City, town, or county) (State) BLADENBURG, MARYLAND	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR DEC 28 1965		24b. REGISTRAR'S SIGNATURE J. Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
16829 20211									
1. PLACE OF DEATH a. COUNTY Prince George's					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham Md					c. LENGTH OF STAY IN 1b X Lewisdale, Md.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Magnolia Nursing home					d. STREET ADDRESS 2101 Amherst Road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Mary Middle M. Last France			4. DATE OF DEATH Dec 24, 19 65						
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME John Watson					14. MOTHER'S MAIDEN NAME Matilda Clark				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Edward Sparrough Lewisdale, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X Congestive heart failure Hypertensive Atherosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malignant melanoma									INTERVAL BETWEEN ONSET AND DEATH 1 yr 50 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept 1950, to 12/24, 19 65, that (I) (we) last saw the deceased alive on 12/24 19 65, and that death occurred at 4 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Julius Kauffman								22b. DATE SIGNED 12/24/65	
22c. PHYSICIAN'S NAME (Type) JULIUS KAUFFMAN, M.D.								22d. ADDRESS 6501 LANDOVER RD. CHEVERLY, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec 28, 1965		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery			23d. LOCATION (City, town or county) (State) Washington D C.	
24. FUNERAL DIRECTOR F. Gasch's Sons, 16401ville, Md.					25a. REC'D BY REGISTRAR DEC 29 1965		25b. REGISTRAR'S SIGNATURE Charles Judge		

11805

THE LIFE OF DEATH

993

THE LIFE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
16830											
20212											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGE'S GEN HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X GLENDALE</b> d. STREET ADDRESS <b>BOX 33 TELEGRAPH</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>GUSTAV</b>			First <b>GUSTAV</b>		Middle <b>FRONCK</b>		Last <b>FRONCK</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>31</b> Year <b>1965</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 6, 1901</b>		9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MEAT CUTTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MEAT MARKET</b>		11. BIRTHPLACE (County & State, or foreign country) <b>GERMANY</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>JOHN FRONCK</b>						14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>577-12-5589</b>		17. INFORMANT <b>ENA P. FRONCK</b>			Address <b>SAME AS #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Sudden Coronary occlusion</b> DUE TO (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>several</b> <b>years</b> <b>several</b> <b>years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <b>Hour</b> <b>11:30 AM</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 1964, to <b>12/31</b> , 1965, that (I) (we) last saw the deceased alive on <b>12/31</b> , 1965, and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>James Kurtz</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>1-1-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>H. James Kurtz</b>						22d. ADDRESS <b>RFD Glendale Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-4-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM</b>				23d. LOCATION (City, town or county) (State) <b>BLADENSBURG, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>W.W. Chambers Co Riverdale, Md.</b>						25a. REC'D BY REGISTRAR <b>JAN 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16831 CERTIFICATE OF DEATH 20213

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> c. LENGTH OF STAY IN 1b <u>years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9100 Adelphi Road</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>9100 Adelphi Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAGDALENA</u> First Middle Last 4. DATE OF DEATH <u>12</u> Month <u>9</u> Day <u>1965</u> Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 22 1884</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Frank Dyer</u> 14. MOTHER'S MAIDEN NAME <u>Emma Fayett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>579 281112</u> 17. INFORMANT <u>Mrs. Rosemary E. Royz</u> Address <u>(same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 443X } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis &amp; hypertensive cardiovascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>1957</u> , 19 <u>  </u> , to <u>12-9</u> , 19 <u>65</u> , that (2) (we) last saw the deceased alive on <u>12-8</u> , 19 <u>65</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>R.D. Bauer MD</u>		22b. DATE SIGNED <u>12-10-65</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, MD</u>		22d. ADDRESS <u>2513 Bulkledge Rd. Adelphi, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Dec. 13, 1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington DC</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Carroll Rd. N.W.</u>		25a. REC'D BY REGISTRAR <u>DEC 13 1965</u>	25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>

MEDICAL CERTIFICATION



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16832

Item #9 Film #G372 1/5/66 no

20214

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>COTTAGE CITY</u> c. LENGTH OF STAY IN 1b <u>30+ yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3710 PARKWOOD ST</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>COTTAGE CITY</u> d. STREET ADDRESS <u>3710 PARKWOOD ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Clyde C GASKILL</u>		<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>28</u> Year <u>1965</u>					
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan 17, 1883</u>	<b>9. AGE</b> (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Printer-S.P.O.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MIA MINNESOTA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>George W. Gaskill</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Beine</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Adm Gaskill Cottage City, Md -</u>		<b>17. INFORMANT</b> Address <u>Adm Gaskill Cottage City, Md -</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> (b) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>30 min</u> <u>3 mos</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 6, 1965</u> <b>to</b> <u>Dec 28, 1965</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 19, 1965</u> <b>and that death occurred at</b> <u>5:30 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Norman D. Cmean</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12/28/65</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>NORMAN D. Cmean</u>		<b>22d. ADDRESS</b> <u>3503 Penny St Mt Airy Md</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Dec 31, 1965</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft Lincoln Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) (State) <u>Colmar Manor, Md.</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>JAN 3 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item # 1 Film # G372 12/26/65 DC											
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 19103 Wallace Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Earl Middle Last Gatewood			4. DATE OF DEATH Month December Day 4 Year 19 65			5. SEX Male			6. COLOR OR RACE Colored		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6/11/02			9. AGE (In years last birthday) 63 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer			10b. KIND OF BUSINESS OR INDUSTRY Webster College			11. BIRTHPLACE (County & State, or foreign country) Madison, Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Louis O. Gatewood						14. MOTHER'S MAIDEN NAME Mary E. Tollover					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Edna Gatewood - Lanham, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5702 TOXIC AND SHOCK IN TESTES DUE TO (b) Necrosis of lungs and small DUE TO (c) mesenteric thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I (this hospital) attended the deceased from 12-3, 1965, to 12-4, 1965, that I (we) last saw the deceased alive on 12-4, 1965, and that death occurred at 8 AM, from the causes and on the date stated above.											
22a. SIGNATURE Amir S. Banisadr, M.D.						22b. DATE SIGNED 12-4-65			22c. PHYSICIAN'S NAME (Type) Amir S. Banisadr, M.D.		
22d. ADDRESS 6323 Landover Rd., Cheverly, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried			23b. DATE THEREOF 12-7-65			23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park Prince Georges, Md.			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR John T. Rhinehart & Co. 3015 12th St. N.E.						24a. ADDRESS 3015 12th St. N.E.			24b. DATE 12-4-65		

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George Washington University  
Washington, D.C.  
1900

Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the above named student.  
The same has been referred to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,  
J. H. [Signature]

Very truly yours,  
J. H. [Signature]  
1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB c. LENGTH OF STAY IN 1b 1 Month d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY ARLINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 834-3 d. STREET ADDRESS 840 S DICKERSON ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First OUIDA Middle KNIGHT Last GEESEY			4. DATE OF DEATH Month DECEMBER Day 19 Year 1965			5. SEX FEMALE			6. COLOR OR RACE CAUC		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 21 APRIL 21			9. AGE (In years last birthday) 44 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY at home				11. BIRTHPLACE (County & State, or foreign country) GEORGIA			
12. CITIZEN OF WHAT COUNTRY? USA						13. FATHER'S NAME CARL L KNIGHT					
14. MOTHER'S MAIDEN NAME JULIA BROOKS						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					
16. SOCIAL SECURITY NO. 248-24-9143						17. INFORMANT HUSBAND Address SAME AS ITEM #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown Cause</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver with ascites and gastric intestinal hemorrhage.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 18, 1965</u> , to <u>Dec 19, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 19, 1965</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>David S. Miller, Capt USAF MC</u>										22b. DATE SIGNED <u>Dec 27, 65</u>	
22c. PHYSICIAN'S NAME (Type) DAVID S MILLER, CAPT, US AF, MC										22d. ADDRESS USAF HOSP ANDREWS AFB MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12-22-65</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery, Sumter, South Carolina</u>			
23d. LOCATION (City, town or county)				23e. (State)				24. FUNERAL DIRECTOR <u>W.W. Chambers &amp; Sons, 517-11, H. &amp; E.</u>			
25a. REC'D BY REGISTRAR <u>DEC 27 1965</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



12 SUSP

ALABAMA

ANNISTON

1. HENRY

FRANCIS GLOUCESTER

ANNISTON

US AIR FORCE HOSPITAL

CRASSY

MAHONEY

OUTER

FRANK CAC

21 APRIL 51

GEORGIA

HOSPITAL

JULIA BROWN

PAUL B. BROWN

248-20-21-5 (ALABAMA) - 248-20-21-5 (ALABAMA)

PAUL B. BROWN. CHIEF. US AIR FORCE HOSPITAL. ANNISTON, ALABAMA

1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16835 CERTIFICATE OF DEATH 20217

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Heights</b> d. STREET ADDRESS <b>324 Terrell Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bernard J. George Sr.</b>		4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>19 65</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1878</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>65</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Frescoer and Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick H. George</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Rose Shifflett</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO <b>Cerebral arteriosclerosis</b> (b) <b>Generalized arteriosclerosis</b> DUE TO <b>Generalized arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>acute pyelonephritis &amp; anemia</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 5</b> , 1965, to <b>Dec. 6</b> , 1965, that (I) (we) last saw the deceased alive on <b>Dec. 6</b> , 1965, and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Don B. Cameron</b> M.D.		22b. DATE SIGNED <b>6 Dec. 1965</b>	
22c. PHYSICIAN'S NAME (Type) <b>Don B. Cameron, M.D.</b>		22d. ADDRESS <b>3503 Perry St. Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>12-10-65</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1965</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16836 CERTIFICATE OF DEATH 20218									
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			c. LENGTH OF STAY IN 1b <u>2 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Leland Memorial Hospital</u>					d. STREET ADDRESS <u>6902 43rd Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>A.</u> Last <u>Gibbons</u>			4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>19 65</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-91</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Fitzgerald</u>					14. MOTHER'S MAIDEN NAME <u>Mary A Smallcomb</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Medical Record/ daughter in law</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CHOLECYSTITIS + HEPATIC ABSCESSES</u> <u>584X</u> DUE TO <u>AND JAUNDICE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BILIARY OBSTRUCTION BY CALCULI</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>2 WKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> , 19 <u>65</u> , to <u>8 DEC.</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>8 DEC</u> , 19 <u>65</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>C. J. Houmann</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8 DEC. 1965</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. J. Houmann, M. D.</u>				22d. ADDRESS <u>4408 Queensbury Road, Riverdale, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-11-65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wolvet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D. C.</u>			
24. FUNERAL DIRECTOR <u>F. Sarsis Sons Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 16 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

gwb.

1951

RECEIVED

1951

Wm. A. Sullivan

Honor Wife



12-11-51  
E. J. Sullivan  
1000 1st St.  
New York, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>1 mo., 25 dys</b>		d. STREET ADDRESS <b>70 Rhode Island Ave. N. E.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rosena</b> Middle <b>Gibson</b> Last <b>Dec</b>		4. DATE OF DEATH Month <b>15</b> Day <b>1965</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/6/1889</b>
9. AGE (in years last birthday) <b>76 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Alexander Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Handy</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Rhodes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Had none</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertensive cardiovascular disease</b> DUE TO (c) <b>arteriolar nephrosclerosis with renal failure</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>pulmonary tuberculosis, chronic pyelonephritis, generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b> <b>unknown</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 20, 1965</b> to <b>Dec. 15, 1965</b> , that (I) (we) last saw the deceased alive on <b>Dec. 15, 1965</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>12/15/65</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-21-1965</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Malven &amp; Schey, Inc.</b>		25a. REC'D BY REGISTRAR <b>DEC 20 1965</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



50519

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Prince Georges

Glenn Dale (viral)

Glenn Dale Hospital

London

London

London

London

London

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London

London

London

London

Dec. 30

12/15/42

Glenn Dale Hospital  
Glenn Dale, Maryland

Dec. 30, 1942

Harold

12-21-1942

Washington National

Arlington, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Geprges General Hospital</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b> d. STREET ADDRESS <b>7105 Webster St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <b>Bertha H Godfrey</b>			<b>4. DATE OF DEATH</b> <b>Dec. 29, 1965</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN HOME</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WILMINGTON, DELA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S</b>		<b>8. DATE OF BIRTH</b> <b>14 Mar., 1887</b>		
<b>13. FATHER'S NAME</b> <b>LEWIS HINKLE</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>AMELIA BARKHORN</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>MRS ERMA E HANDS</b> <b>CORB ISLAND MD</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>5400</b> <b>Marked Bilateral pulmonary Edema</b> (b) <b>Multiple bleeding gastric ulcers</b> (c) <b>ulcers</b> <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)								
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>June</b> , 19 <b>57</b> , to <b>12/26, 1965</b> , that <b>we</b> last saw the deceased alive on <b>12/26, 1965</b> , and that death occurred at <b>12:55 AM</b> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <b>F.E. MUSER</b>			<b>22b. DATE SIGNED</b> <b>12/27/65</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>F.E. MUSER</b>		<b>22d. ADDRESS</b> <b>4410 7th Ave, Hyattsville, Md</b>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12-31-65</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>GREENHILL</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>WILMINGTON, DELAWARE</b>					
<b>24. FUNERAL DIRECTOR</b> <b>W.W. Chambers Co. Riverdale Md</b>				<b>25a. REC'D BY REGISTRAR</b> <b>JAN 3 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>					

MEDICAL CERTIFICATION

10033

Prince Rupert

Maritime

Prince Rupert

Landover Hill

3 days

Conveyer

1100 Western St.

Prince Rupert General Hospital

Dec. 1941  
Mar. 1942

Conveyer

Maritime

White

White

*[Faint, illegible handwriting]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delphi</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PAINT BRANCH Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>2123 I St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Phillip</u> Last <u>Guckert</u>		4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1965</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-1870</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Plate Engraver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carl Guckert</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite Rauffert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFIRMITY <u>William Guckert</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> 10 yrs. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Simple removal of one kidney and prostate.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that <u>R.D. Bauer</u> attended the deceased from <u>1-27</u> , 19 <u>65</u> , to <u>12-13</u> , 19 <u>65</u> , that <u>he</u> last saw the deceased alive on <u>12-13</u> , 19 <u>65</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>R.D. Bauer M.D.</u>		22b. DATE SIGNED <u>12-13-65</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, M.D.</u>		22d. ADDRESS <u>2513 Buck Lodge Rd - Delphi, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>12-15-65</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>4843 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 17 1965</u>			

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1883

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310 1st St NW  
1st Branch Meeting House  
William Phillips

12-20-1883  
New York  
Rail Cuckoo

Admission 10 c  
10 c

12-20-1883  
10 c

1883



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 5-63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> e. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>EUGENE LELAND MEMORIAL HOSPITAL</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRENTWOOD</b> d. STREET ADDRESS <b>4512 35TH PLACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARY</b> <b>ETHEL</b> <b>HARMAN</b> First Middle Last <b>4. DATE OF DEATH</b> <b>DECEMBER 8 1965</b> Month Day Year						<b>5. SEX</b> <b>FEMALE</b> <b>6. COLOR OR RACE</b> <b>CAUCASIAN</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>NOVEMBER 25, 1974</b> <b>9. AGE</b> (In years last birthday) <b>91 yrs.</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>PENNSYLVANIA</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>JACOB CORP</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> <b>16. SOCIAL SECURITY NO.</b> <b>unk.</b> <b>17. INFORMANT</b> <b>BESSIE GRAY - DAUGHTER (SAME AS ABOVE)</b> Address						<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY WELTY</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (a), stating the underlying cause last. (c) <b>GENERAL ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 10 yrs</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5:45 PM DEC 7</b> <b>1965</b> <b>to</b> <b>DEC 8</b> <b>1965</b> , that (I) (we) last saw the deceased alive on <b>DEC 7</b> <b>1965</b> , and that death occurred at <b>5:25 AM</b> , from the causes and on the date stated above. <b>22a. SIGNATURE</b> <b>L W Malin</b> <b>M.D.</b> <b>22b. DATE SIGNED</b> <b>12-8-65</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>L W Malin M.D.</b> <b>22d. ADDRESS</b> <b>Riverdale, Md.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>Dec 10, 1965</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Lincoln Cemetery</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Colmar Manor, Md.</b>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. Lassch's Sons, Hyattsville, Md.</b> <b>ADDRESS</b> <b>Gu.B.</b> <b>25a. REC'D BY REGISTRAR</b> <b>DEC 13 1965</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>											

MEDICAL CERTIFICATION



3008

OFFICE OF THE

1930

1930

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

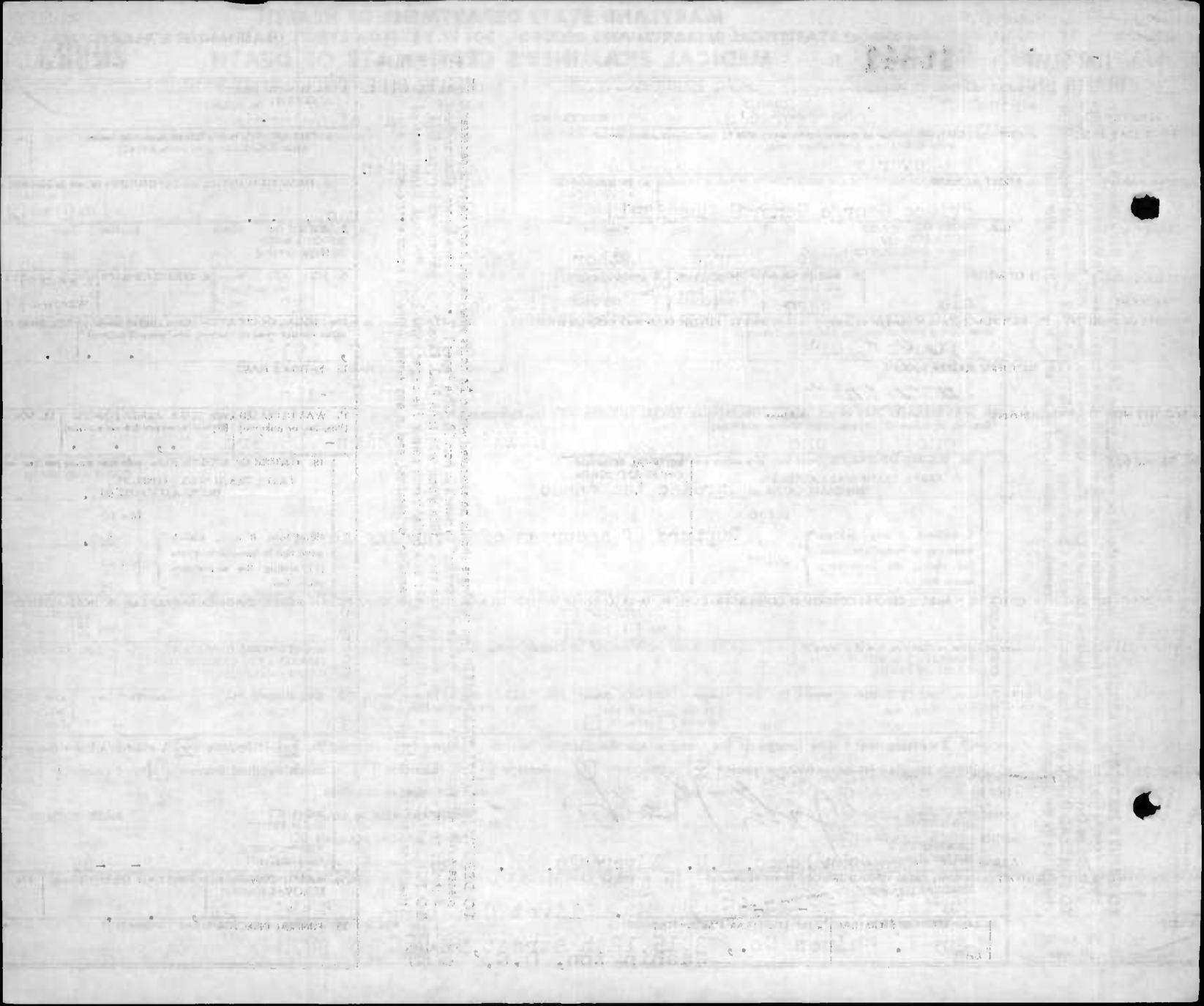
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16841

20223

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
e. LENGTH OF STAY in 1b DOA				d. STREET ADDRESS 515 3rd. Street, N.E.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Monroe Luther Haskins				4. DATE OF DEATH Month 12 Day 17 Year 19 65			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 Jan. 1938	
9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) January 2, 1938				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Monroe Smith				14. MOTHER'S MAIDEN NAME Lillian Harris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Lillian Haskins-515 3rd St., N. E.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac tamponade 451X DUE TO (b) Rupture of aneurysm of ascending aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				DATE SIGNED 12-19-65			
EXAMINER'S NAME (Type) John Kehoe, M.D.				Address (Street, city, town, or county) Riverdale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-65		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR John T. Rhines Co., 3015 12th Street, NE, Washington, D.C.				24a. REC'D BY REGISTRAR DEC 27 1965			
				24b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

16842

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20224

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Brentwood d. STREET ADDRESS 3707 Upshur Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital									
3. NAME OF DECEASED (Type or print) First Middle Last Anna Margaret Herath				4. DATE OF DEATH Month Day Year 12 21 19 65					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 April 1886		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Tanner				14. MOTHER'S MAIDEN NAME K. Schlenke					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Anna M. Leftwich-Daughter-Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH 5 days over 10 yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12-21-65	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 24-65		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR ADDRESS Simmons Bros. - 1661-Good Hope Rd SE Wash DC				24a. REC'D BY REGISTRAR DATE DEC 27 1965		24b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

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STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

20226

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clifton Bourroughs Hickerson		4. DATE OF DEATH Month Day Year 12 9 1965	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1893
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY State Government	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Hubert Clifton Hickerson		14. MOTHER'S MAIDEN NAME Nannie ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes unknown		16. SOCIAL SECURITY NO. 578 24 8840	
17. INFORMANT James H. Hickerson, Son/Medical Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral thrombosis (b) General arteriosclerosis (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 18 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 14, 1965, to 12-9, 1965, that (I) (we) last saw the deceased alive on Dec 8, 1965, and that death occurred at 8:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE L W Malin		22b. DATE SIGNED 12-9-65	
22c. PHYSICIAN'S NAME (Type) L W Malin MD		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/13/65	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 13 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		c. LENGTH OF STAY IN 1b <b>Dec. 1962</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>12301-Kemmerton Lane</b>		e. STREET ADDRESS <b>12301-Kemmerton Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Felix</b> Middle <b>F.</b> Last <b>Hill</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>10</b> Year <b>19 65</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/24/1896</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mt. Pleasant, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hilinski</b>		14. MOTHER'S MAIDEN NAME <b>Mary Orvitsky</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-03-9557</b>	
17. INFORMANT <b>Mrs. Estelle M. Hill (above address)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral tumor (astrocytoma), left</b> 1930 DUE TO <b>temporal lobe.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1962</b> to <b>10 Dec. 1965</b> , that (I) (we) last saw the deceased alive on <b>12-8-1965</b> , and that death occurred at <b>6:50 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John Cosma</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOHN COSMA, M.D.</b>		22d. ADDRESS <b>3010 STONY BROOK AVE, BOWIE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/13/1965</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>DEC 16 1965</b>	
ADDRESS <b>Mt. Rainier, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16846

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook</b> d. STREET ADDRESS <b>6502 94th. Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bruce Edward Holzer</b>		4. DATE OF DEATH Month Day Year <b>12 20 19 65</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8 Aug. 1921</b>
9. AGE (In years last birthday) <b>44 1/3 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>44 1/3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service station operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas station</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Howard Holzer</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Lee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes ww 11</b>		16. SOCIAL SECURITY NO. <b>ww 11</b>	
17. INFORMANT <b>Carol E Holzer</b>		Address <b>Landover Hills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b> 976X Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO</b> (c) <b>DUE TO</b> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot self in head.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head.</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:30 p.m. 12-19- 19 65</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4214 75th. Avenue, Landover Hills, Md.</b>		20f. (City or town) (County) (State) <b>Landover Hills, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		M.D. <b>John Kehoe, M.D.</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 22, 1965</b>	
22c. NAME OF CEMETERY OR INTERMENT <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 27 1965</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16847 CERTIFICATE OF DEATH 20229									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>3 mo., 29 dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>478-3</b> d. STREET ADDRESS <b>1531 8th St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Arthur Hood</b>			First Middle Last		4. DATE OF DEATH <b>Dec. 19 19 65</b>		Day Month Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/18/1889</b>		9. AGE (in years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Smithfield, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Right Hood</b>					14. MOTHER'S MAIDEN NAME <b>Amada Saunders</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>decedent</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> 4201 OUE TO (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b> OUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>BRONCHOPNEUMONIA, PYELONEPHRITIS</b>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
21. I certify that (I) (this hospital) attended the deceased from <b>8/20 1965</b> to <b>12/19 1965</b> , that (I) (we) last saw the deceased alive on <b>12/19 1965</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Moe Weiss</b>					22b. DATE SIGNED <b>12/19/65</b>		22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		
22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>					22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-23-65</b>			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY <b>Smithfield, N.C.</b>			23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <b>P.N. Horton Co. 1324 1/2 St. N.W.</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>DEC 27 1965</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>



1947

George Jones

John Doe (son)

John Doe Hospital

Admission

John Doe

Medical

John Doe

Dr.

John Doe

John Doe

Acute Myocardial Infarction

Antihypertensive Agent 1/1/47

Generalized Arteriosclerosis

Alcoholism, Nervous, Depression

1947

John Doe Hospital  
John Doe, Maryland

John Doe, N. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> <span>16848</span> <span>Item #2 a, e &amp; d 11m 7G-12 1/20/66 pc</span> <span>20230</span> </div>											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>6 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MISSISSIPPI</b> b. COUNTY <b>WINN</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>COLUMBUS/AIR FORCE BASE</b> d. STREET ADDRESS <b>Rt. #2 Church Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First <b>JOBE</b>			Middle <b>NMI</b>			Last <b>HOWELL</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 May 1919</b>		9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OFFICER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US AIR FORCE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOBE R HOWELL</b>						14. MOTHER'S MAIDEN NAME <b>BLANCH R. Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>362-14-0330</b>		17. INFORMANT Address <b>Military Records, Andrews AFB, Wash, DC</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> (b) <b>cachexia</b> (c) <b>carcinomatosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from <b>24 Dec</b> , 19 <b>65</b> , to <b>30 Dec</b> , 19 <b>65</b> , that (X) (we) last saw the deceased alive on <b>30 Dec</b> , 19 <b>65</b> , and that death occurred at <b>12:28</b> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas J. Fiene</b>						22b. DATE SIGNED <b>30 Dec 65</b>					
22c. PHYSICIAN'S NAME (Type) <b>THOMAS J. FIENE, CAPT, USAF</b>						22d. ADDRESS <b>USAF Hospital Andrews, Wash, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Inc. 517-11th St. S.E.</b>						25a. REC'D BY REGISTRAR <b>IAN 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

303-10

10328

INTERESTING

PRINCE GEORGE'S

COLUMBUS AIR FORCE BASE

ANDREWS AIR FORCE BASE 6 WAYS

NEAR HOSPITAL ADDRESS

DECEMBER 23 1953

HOWELL

WNY

JOBE

1953 NOV 12 1953

CAN

NAME

US AIR FORCE

OFFICER

MARCH 2

JOHN S. HORN

Military Academy

24 DEC 25 1953

30 DEC 25 1953

10328

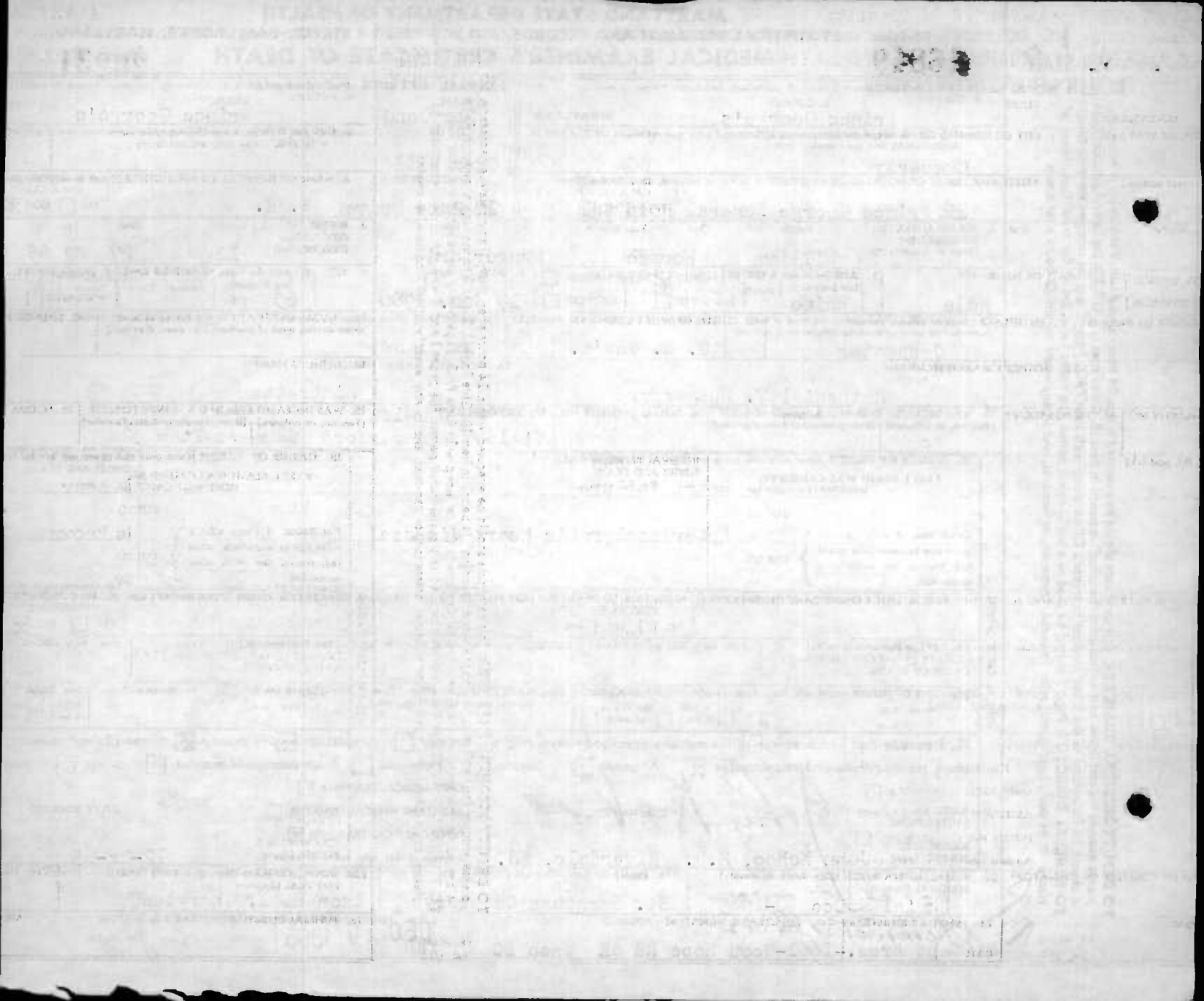
THOMAS J. TIERNEY, CAPT. USAF

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/63

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<div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div>											
<b>1. PLACE OF DEATH</b> e. COUNTY <u>Prince George's</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY in 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12 Prince George General Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u> d. STREET ADDRESS <u>12 Pate Drive S. E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>William</u> <u>Horace</u> <u>Hungerford</u>						<b>4. DATE OF DEATH</b> Month Day Year <u>12</u> <u>27</u> <u>19 65</u>					
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>19 Jan. 1900</u> <b>9. AGE</b> (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U. S. Gov't.</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>											
<b>13. FATHER'S NAME</b> <u>Nathaniel T. Hungerford</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>? Mistretta</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>no</u> <b>17. INFORMANT</b> <u>Wife</u> Address <u>Viola T. Hungerford Same as Item #2</u>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic heart disease</u> (c), stating the underlying cause last. <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . ACTUAL SIGNATURE <u>John Kehoe</u> M.D. EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-28-65</u>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>Dec 30-1965</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Barnabas Cemetery</u> <b>22d. LOCATION (City, town, or county)</b> <u>Oxon Hill, Maryland</u> (State)											
<b>23. FUNERAL DIRECTOR</b> <u>Simmons Bros</u> ADDRESS <u>1661-Good Hope Rd SE Wash DC</u> <b>24. REC'D BY REGISTRAR</b> <u>DEC 30 1965</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND #6850 CERTIFICATE OF DEATH 20232													
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Laurel General Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Md b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buntanville 15X-2 d. STREET ADDRESS 14901 Columbia Road. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) ELIZABETH First Middle Last 4. DATE OF DEATH 12 13 1965 5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Sept 4 1908 57 yrs. 9. AGE (In years last birthday) 57 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government 11. BIRTHPLACE (County & State, or foreign country) Macon, Georgia 12. CITIZEN OF WHAT COUNTRY? USA													
13. FATHER'S NAME Ernest Arnett 14. MOTHER'S MAIDEN NAME Francis Brown Adams 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Karen Hurst, Buntanville Md Address													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 5721 DUE TO Colectomy Operation 10 day (b) RUPTURED DIVERTICULUM 33 day (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Instant.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 2/18 1946, to 12/13 1965, that (I) (we) last saw the deceased alive on 12/13 1965, and that death occurred at 4:30 P.M. from the causes and on the date stated above. 22a. SIGNATURE J.M. Warren 22b. DATE SIGNED 12/15/65 22c. PHYSICIAN'S NAME (Type) J.M. Warren 22d. ADDRESS Laurel Md 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12-16-65 23c. NAME OF CEMETERY OR CREMATORY St. Marks Cem 23d. LOCATION (City, town or county) (State) Fairland Md 24. FUNERAL DIRECTOR Bellitt Danielson 25a. REC'D BY REGISTRAR DEC 17 1965 25b. REGISTRAR'S SIGNATURE Charles Judge													



10850

10853

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>16851 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> e. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fairmont Heights</u> d. STREET ADDRESS <u>5802 Sheriff Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>NELLIE</u> Middle <u>LOUISE</u> Last <u>JACKSON</u>						<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>1</u> Year <u>1965</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>26 June 1940</u>		<b>9. AGE</b> (In years last birthday) <u>25</u> yrs. IF UNDER 1 YEAR: Months <u>12</u> Days <u>1</u> Hours <u>19</u> Min. <u>65</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Washington DC</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>USA</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Washington</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Louise Spriggs</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>John A. Jackson</u> <b>17. INFORMANT</b> <u>John A. Jackson</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>From metastatic carcinoma of brain and lungs</u> DUE TO (c) <u>From Hypernephroma left kidney</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>minutes</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>John Kehoe</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>12-2-65</u>			
<b>EXAMINER'S NAME</b> (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>12-6-65</u>				<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt Olivet Cem</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Bladensburg Rd NE Wash DC</u>		<b>(State)</b>	
<b>23. FUNERAL DIRECTOR</b> <u>Henry S. Washington &amp; Sons - 4925 Main Ave</u>						<b>ADDRESS</b>		<b>24a. REC'D BY REGISTRAR</b> <u>DEC 7 1965</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

MEDICAL CERTIFICATION

1935

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*Handwritten signature*  
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*Handwritten signature*  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>						c. LENGTH OF STAY IN 1b <b>Li fetime</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Brandywine-Waldorf Med. Clinic</b>						e. STREET ADDRESS <b>Rt. 3-Box 363</b>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Willie Joseph Johnson</b>						<b>4. DATE OF DEATH</b> Month Day Year <b>December 1 1965</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 9, 1915</b>		<b>9. AGE</b> (In years last birthday) <b>50</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Custodial</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Prince George's Co. Md.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>Willie Johnson</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Henrietta Smith</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes War #2-</b>				<b>16. SOCIAL SECURITY NO.</b> <b>213020-5151</b>		<b>17. INFORMANT</b> <b>Mrs. Gladys Porter-Rt. 3-Box 363</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>Brandywine, Md.</b> <b>443x</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>24 hrs</b> <b>YEARS</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>6/1, 1965</b> , to <b>12/1, 1965</b> , that (I) (we) last saw the deceased alive on <b>11/1, 1965</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <b>Thomas L. Fieldson</b>						<b>22b. DATE SIGNED</b> <b>1 Dec 1965</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Thomas L. Fieldson</b>		<b>22d. ADDRESS</b> <b>Brandywine, Md. 20613</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>Dec. 4, 1965</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Gibbons Meth. Ch. Cem. Brandywine, Md.</b>		<b>23d. LOCATION</b> (City, town or county) (State)			
<b>24. FUNERAL DIRECTOR</b> <b>Martell Adams</b>				<b>ADDRESS</b> <b>Aquasco, Md.</b>		<b>25a. REG'D BY REGISTRAR</b> <b>DEC 7 1965</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>			

10000

10000

STATE OF NEW YORK  
IN SENATE  
January 1, 1900  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899  
ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.  
1900.

RECEIVED JAN 1 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
16853					20235							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY Prince Georges					a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					b. COUNTY Prince Georges							
c. LENGTH OF STAY IN 1b m 2 hrs 10 m					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hillside							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 1525 59th Ave.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year			
Baby Boy			Kavadias			Dec. 21			19 65			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		21 Dec., 1965		yrs.		Months Days Hours Min.		
										x2x 2 10		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country)		
										Maryland		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
William Jerry Kavadias					Ifigenia Rousson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 7625 DUE TO <i>ateletasis of the lungs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Weight - 600 lbs. Measures - crown to heel 89 ins; C to hip - 32 in.</i> (c)										INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>maternal circulate infarct.</i>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Dec. 21, 19 65 to Dec. 21, 19 65, that (I) (we) last saw the deceased alive on Dec. 21, 19 65, and that death occurred at 2:20 AM, from the causes and on the date stated above.												
22a. SIGNATURE <i>H. E. Altman</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/21/65		
22c. PHYSICIAN'S NAME (Type) Harry Earle Altman, M.D.						22d. ADDRESS 2025 Eye St. N.W. Washington 7, D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation			23b. DATE THEREOF 12/24/65		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hosp			23d. LOCATION (City, town or county) (State) Cheverly Maryland				
24. FUNERAL DIRECTOR <i>Harry W. Penn, Jr.</i>						25a. REC'D BY REGISTRAR DATE DEC 28 1965		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

Harry W. Penn, Jr., Administrator

5-1485 PL



40123

Office of the  
Director of the  
Bureau of the  
Census  
Washington, D.C.  
20540

Mr. J. Edgar Hoover  
Director  
Federal Bureau of Investigation  
Washington, D.C.  
20535

Dear Mr. Hoover:

I am writing to you regarding the matter of the  
Bureau of the Census and the Bureau of the  
Investigation.

I am sure that you will find this information  
of interest.

Sincerely,  
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16854 CERTIFICATE OF DEATH 20236											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE 45 DAYS c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US AIR FORCE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ALEXANDRIA 83X-3 d. STREET ADDRESS 632 NORTH RIPLEY ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MERLE ANNA KELLER			4. DATE OF DEATH DECEMBER 3 1965			5. SEX FEMALE			6. COLOR OR RACE CAUC		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 11 APRIL 1898 69 yrs.			9. AGE (In years last birthday) 69 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Nurse			11b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (County & State, or foreign country) ST MARYS COUNTY MD			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME GEORGE CLARENCE THOMPSON						14. MOTHER'S MAIDEN NAME MARY AGNES WIBLE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No			16. SOCIAL SECURITY NO. 577-56-6834			17. INFORMANT DAUGHTER			Address SAME AS ITEM #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 5810 DUE TO Bleeding esophageal varices (b) DUE TO Cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None									INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours Years		
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 20, 1965, to Dec 4, 1965, that (I) (we) last saw the deceased alive on Dec 4, 1965, and that death occurred at 7 AM, from the causes and on the date stated above.											
22a. SIGNATURE Charles D Phelps						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 4 Dec 65		
22c. PHYSICIAN'S NAME (Type) CHARLES D PHELPS, CPT USAF MC						22d. ADDRESS USAF HOSP ANDREWS WASH DC 20331					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec 7, 1965			23c. NAME OF CEMETERY OR CREMATORY Arlington Natl.			23d. LOCATION (City, town or county) (State) Arlington Va		
24. FUNERAL DIRECTOR W.W. Chambers Co.						ADDRESS 517-11 1/2 St. SE Wash, DC			25a. REC'D BY REGISTRAR DEC 6 1965		
						25b. REGISTRAR'S SIGNATURE [Signature]					

20034

20034

VERMONT

APRIL 1962

222 NORTH LAMONT ST

WATERBURY

VERMONT

APRIL

1962

APRIL 1962

ST. MARY'S COUNTY MD

MARY ANN S. WILSON

DAUGHTER

DATE OF BIRTH

DEC 1962

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16855 CERTIFICATE OF DEATH 20237											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>27 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b> d. STREET ADDRESS <b>901 67th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Kredeio</b>			First <b>Kredeio</b>		Middle <b>Kelliebrew</b>		Last <b>Kelliebrew</b>		4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>19 65</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 22, 1965</b>		9. AGE (In years last birthday) yrs. <b>2</b> Months <b>22</b> Days <b>22</b>		IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min. <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Terry R. Ingraham</b>						14. MOTHER'S MAIDEN NAME <b>Mary Kelliebrew</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Mary Kelliebrew</b>		Address <b>Same as 2D</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition and dehydration, severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cause unknown</b> DUE TO (c) <b>7720</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <del>my</del> (this hospital) attended the deceased from <b>Nov. 17</b> , 19 <b>65</b> , to <b>Dec. 14</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec. 14</b> , 19 <b>65</b> , and that death occurred at <b>3:04</b> PM, from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas A. Christensen</b>						M.O. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/15/65</b>		22c. PHYSICIAN'S NAME (Type) <b>Thomas A. Christensen, M.D.</b>	
22d. ADDRESS <b>6905 Baltimore Ave. College Park, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <b>12-18-65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem.</b>			23d. LOCATION (City, town or county) (State) <b>Highland Pk. Md.</b>			
24. FUNERAL DIRECTOR <b>H.S. Washington</b>						ADDRESS <b>Sm 4925 Dean Ave NE</b>		25a. REC'D BY REGISTRAR <b>DEC 21 1965</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

5-152881

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10000

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May 10, 1962

12-18-62  
112 Washington Ave  
Highland Park, N.J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16856 CERTIFICATE OF DEATH 20238									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairmont Heights				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 5900 L. Street N.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosie Franklin Kirkland			4. DATE OF DEATH Month Day Year December 17 19 65						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25 1877		9. AGE (In years last birthday) 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (County & State, or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Alice Lewis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Josephine Blake 5341 Hunt Pl., N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema 4201 DUE TO Myocardial infarction, acute (b) DUE TO Atherosclerotic heart disease (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 11, 1965, to Dec. 17, 1965, that (I) (we) last saw the deceased alive on Dec. 17, 1965, and that death occurred at 3:30 p.m. from the causes and on the date stated above.									
22a. SIGNATURE Don B. Cameron						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 17, 1965	
22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D.						22d. ADDRESS 3503 Perry St., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-21-65		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem.			23d. LOCATION (City, town or county) (State) Suitland Rd Md		
24. FUNERAL DIRECTOR H.S. Washington Sons 4925 Deane One N 3						25a. REC'D BY REGISTRAR DEC 23 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	



05692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
16857 CERTIFICATE OF DEATH 20239										
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 7 hr. 57 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 7702 Alpine Street S.E.					
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Knight					4. DATE OF DEATH Month Day Year December 3 1965					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1965		9. AGE (In years last birthday) yrs. Months Days 7 7 57		10. UNDER 1 YEAR Months Days 7 57		11. UNDER 24 HRS. Hours Min. 7 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --			10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Walter Knight					14. MOTHER'S MAIDEN NAME Joyce Dennison					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. --		17. INFORMANT Walter J. Knight Same as Item #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) none										INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from birth, 1965, to 12-3-65, 19, that (I) (we) last saw the deceased alive on 9:30 AM 19 and that death occurred at 12:30, from the causes and on the date stated above.										
22a. SIGNATURE M. A. Jansa					22b. DATE SIGNED December 4-1965			22c. PHYSICIAN'S NAME (Type) M. A. Jansa		
22d. ADDRESS 7403-Varnum St. Landover Hills Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec. 6-65		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) (State) Suitland Maryland				
24. FUNERAL DIRECTOR Simmons Bros. 1661-Good Hope Rd SE Wash DC					25a. REC'D BY REGISTRAR DEC 7 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

5-153647



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 20240											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chencery c. LENGTH OF STAY IN 1b DOA Prince George Hospital d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Balt. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 034-2 d. STREET ADDRESS 1253 Linden Avenue					
3. NAME OF DECEASED (Type or print) First Middle Last JAMES ARTHUR KOONS 4. DATE OF DEATH 12 20 1965 5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug 16 1902 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative asst. Dept of Army 10b. KIND OF BUSINESS OR INDUSTRY US. 11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md 12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME James Alfred Koons 14. MOTHER'S MAIDEN NAME Lilly May Smith 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 17. INFORMANT Emily M. Koons, Arbutus Md											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis 10 yrs. (c) Gen. Arteriosclerosis 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 3/30, 1939, to 12/20, 1965, that (I) (we) last saw the deceased alive on 12/20 1965, and that death occurred at M, from the causes and on the date stated above. 22a. SIGNATURE J M Warren 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12-23-65 23c. NAME OF CEMETERY OR CREMATORY Madamida Memorial 23d. LOCATION (City, town or county) (State) Poores Md 24. FUNERAL DIRECTOR W H W Canadian, Laurel, Md 25a. REC'D BY REGISTRAR DEC 27 1965 25b. REGISTRAR'S SIGNATURE J Charles Judge											

10500

10500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div> <div>6</div> <div>1</div> </div> <div> <div>16859</div> <div>20241</div> </div>											
<div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6817 Prince Georges Ave., Takoma Park</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Takoma Park</u> d. STREET ADDRESS <u>6817 Prince Georges Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>JEAN F. LAMBERT</u> First Middle Last <b>4. DATE OF DEATH</b> <u>December 11 1965</u> Month Day Year						<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Jan. 8, 1887</u> <b>9. AGE</b> (In years last birthday) <u>78</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Scotland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>William Jantar</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Janet Todd</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>332-185-841</u> <b>17. INFORMANT</b> <u>Miss Margaret Lambert, Takoma Park, Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spindle cell carcinoma of thyroid</u> <u>194X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 1/2 mos</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>none</u>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>none</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct 12th 1965</u> <b>to</b> <u>DEC 11, 1965</u> <b>that (I) (we) last saw the deceased alive on</b> <u>DEC 4, 1965</u> <b>and that death occurred at</b> <u>6 AM</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Leo J. Schildhaus</u> M.D. <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>						<b>22b. DATE SIGNED</b> <u>12/11/65</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Leo J. Schildhaus, M.D.</u>						<b>22d. ADDRESS</b> <u>6101 NEW HAMPSHIRE AVENUE WASH DC</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>				<b>23b. DATE THEREOF</b> <u>Dec. 15, 1965</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Hope Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Cook County, Illinois</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Warner E. Pumphrey, Inc.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>gcharles Judge</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>gcharles Judge</u>			
<b>25c. ADDRESS</b> <u>8434 Georgia Avenue Silver Spring, Md.</u>				<b>DATE</b> <u>DEC 15 1965</u>							



1258

02971

COLLECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**16860**

**20242**

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 37 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> Maryland <b>b. COUNTY</b> Prince George's <b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville <b>d. STREET ADDRESS</b> 3607 Jefferson Street <b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Frank Lanier			<b>4. DATE OF DEATH</b> Month Day Year December 20 1965				
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> White		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> 9-12-02		<b>9. AGE</b> (In years last birthday) 63 yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Printer			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> linotype		<b>11. BIRTHPLACE</b> (County & State, or foreign country) Davidson Co N. C.		
<b>12. CITIZEN OF WHAT COUNTRY?</b> U S A			<b>13. FATHER'S NAME</b> Umey Lanier				
<b>14. MOTHER'S MAIDEN NAME</b> Palie Smith			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) no (If yes give war or dates of service)				
<b>16. SOCIAL SECURITY NO.</b> 579 07 3047			<b>17. INFORMANT</b> Hospital records Cheverly, Md.				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>adenocarcinoma stomach</i> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pulmonary edema</i>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> 19		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from Nov 13, 1965, to Dec 20, 1965 that (I) (we) last saw the deceased alive on Dec 20, 1965, and that death occurred at 2:15 PM from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Don B. Cameron</i>				<b>22b. DATE SIGNED</b> 12-20-65			
<b>22c. PHYSICIAN'S NAME</b> (Type) DON B. CAMERON				<b>22d. ADDRESS</b> 3503 Perry St Wt. Rainer Md			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>23b. DATE THEREOF</b> Dec 23, 1965		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Chapel Hill			
<b>23d. LOCATION</b> (City, town, or county) Clinton N. C.		<b>23e. (State)</b>					
<b>24. FUNERAL DIRECTOR</b> F Esch's sons Hyattsville Md				<b>25a. REC'D BY REGISTRAR</b> DEC 27 1965			
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>							

MEDICAL CERTIFICATION

DON B. CAMERON

3203 Prof at the University

W. H. H. H.

7 books - one of them is a book of the Bible

1  
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**TITIAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 20242

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY IN 1b <u>1 1/2</u> hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Andrews Air Force Base Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> <b>Prince George's</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> g. STREET ADDRESS <u>Rt. 1, Box 8-10</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Ardena Frances Leake</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>12 2 1965</u>	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12-9-1937</u> <b>9. AGE</b> (In years last birthday) <u>27</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Nurse</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Nursing</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Texas</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>David Elmore Miner</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Leitha Leo Acmond</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war and dates of service) <u>No</u> <u>N/A.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>UNKNOWN</u> <b>17. INFORMANT</b> <u>Husband</u> Address <u>Same as #2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>8234</u> DUE TO <u>From bilateral pneumothorax</u> <u>(b) and laceration of liver</u> DUE TO <u>And retroperitoneal hemorrhage</u> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> <u>Driver, thrown out of car, which ran off road and overturned.</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Driver, thrown out of car, which ran off road and overturned.</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>1:30 p.m. 12-2-1965</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Cedarville Road, 3 miles off Rt. 301, Brandy-</u> <u>wine, Md.</u> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>John Kehoe</u> <b>EXAMINER'S NAME</b> (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>12-3-65</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>12/7/65</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Nevilles Chapel</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Mt. Pleasant, Tex.</u>	
<b>23. FUNERAL DIRECTOR</b> <u>W.W. Chambers Co.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DEC 6 1965</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Prince George's</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Lanham</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Magnolia Gardens Nursing Home</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <i>New York</i> b. COUNTY <i>New York</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>New York</i> 69X-3 d. STREET ADDRESS <i>533 West 113th Street</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <i>Margaret Osborn Lounsbury</i> First Middle Last <b>5. SEX</b> <i>Female</i> <b>6. COLOR OR RACE</b> <i>White</i> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				<b>4. DATE OF DEATH</b> <i>Dec 16 1965</i> Month Day Year <b>8. DATE OF BIRTH</b> <i>4/25/1896</i> <b>9. AGE</b> (In years last birthday) <i>69</i> yrs. <i>9</i> months <i>9</i> days <i>9</i> hours <i>Min.</i>				<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Own Home</i> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Iowa</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>			
<b>13. FATHER'S NAME</b> <i>Herbert Osborn</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>Sales</i>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>no</i> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <i>Myron H. Lounsbury same as #2 (husband)</i> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Smoke</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio sclerosis generalized</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>The</i> <i>8 months</i>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <i>19</i> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>											
<b>21. I certify that (I) (this hospital) attended the deceased from <i>11/21/65</i>, 19<i>65</i> to <i>12/16</i>, 19<i>65</i>, that (I) (we) last saw the deceased alive on <i>12/16</i>, 19<i>65</i>, and that death occurred at <i>10:15</i> M, from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <i>Edith Lounsbury</i> <b>22b. DATE SIGNED</b> <i>12/16/65</i> <b>22c. PHYSICIAN'S NAME (Type)</b> <i>Edward Lounsbury</i> <b>22d. ADDRESS</b> <i>9101 Gait Herd Rd, Lanham, Md.</i> <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i> <b>23b. DATE THEREOF</b> <i>12/18/65</i> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Mt. Hope</i> <b>23d. LOCATION (City, town or county) (State)</b> <i>Westchester Co. N.Y.</i> <b>24. FUNERAL DIRECTOR</b> <i>Francis Gasch's Sons</i> <b>ADDRESS</b> <i>Hyattsville, Md.</i> <b>25a. REC'D BY REGISTRAR</b> <i>DEC 20 1965</i> <b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>											



1953

DEPARTMENT OF HEALTH

1953

New York

John Doe

123 West 123rd Street

Manhattan, New York

4/1/53

62

John Doe

John Doe

John Doe

John Doe

123 West 123rd Street

1953

John Doe

John Doe

John Doe

John Doe

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16863

20245

1. PLACE OF DEATH a. COUNTY <i>Prince Georges'</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>Madison Manor Nursing Home</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Pr. Geo.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>E. Riverdale</i>		d. STREET ADDRESS <i>5424 - 56th Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Ada</i>		Middle <i>V.</i>		Last <i>Lusby</i>		4. DATE OF DEATH <i>Dec. 21, 1965</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/8/96</i>		9. AGE (In years last birthday) <i>69 yrs.</i>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Govt. - G.P.O.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James M. Green</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Gordon</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-58-9376</i>		17. INFORMANT <i>Mrs. Dorothy Couperthwaite - 8438 -</i>		Address <i>57th Ave. Berwyn Hts., Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Bronchopneumonia</i>		57th Ave. Berwyn Hts., Md.		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 1963 to <i>12/21</i> , 1965, that (I) (we) last saw the deceased alive on <i>12/18</i> , 1965, and that death occurred at <i>11 P.</i> M. from the causes and on the date stated above.		22a. SIGNATURE <i>[Signature]</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/22/65</i>		22c. PHYSICIAN'S NAME (Type) <i>Hugh Tracy, M.D.</i>		22d. ADDRESS <i>7105 - Ridge Rd Hyattsville Md</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/24/65</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Suitland, Md.</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's</i>		ADDRESS <i>Funeral Home Inc.</i>		25a. REC'D BY REGISTRAR <i>DEC 28 1965</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25d. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25e. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25f. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25g. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25h. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16864

## CERTIFICATE OF DEATH

20246

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> <b>D.O.A.</b> c. LENGTH OF STAY IN <b>1</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro, Maryland</b> d. STREET ADDRESS <b>Box 1739</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Maude Parrino Lusby</b>				<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>12</b> Year <b>1965</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 26, 1889</b>		<b>9. AGE</b> (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>James Henry Denton</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Louisa Wood</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>---</b>		<b>17. INFORMANT</b> <b>Edward Henry Lusby-</b>		<b>Address</b> <b>Same as Item #2</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO <b>4221</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerotic CardioVasc Disease</b> DUE TO (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 hrs</b> <b>10 yrs</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <b>a.m.</b> <b>p.m.</b>		<b>Month, Day, Year</b> <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1 Dec 1965</b> <b>to</b> <b>12 Dec 1965</b> <b>that (I) (we) last saw the deceased alive on</b> <b>12 Dec 1965</b> <b>and that death occurred at</b> <b>12:20 P.M.</b> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>Robert B. Sasscer, M. D.</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>12/12/65</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b>				<b>22d. ADDRESS</b> <b>Upper Marlboro, Maryland.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/15/65</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Epiphany Cemetery</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Forestville, Md.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ritchie Bros. Upper Marlboro, Md.</b>				<b>ADDRESS</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 27 1965</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	

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James George, Maryland, Upper Marlboro, Maryland

Box 1738, Upper Marlboro, Maryland

May 20, 1965, U.S.A.

James George, Maryland, Upper Marlboro, Maryland

Box 1738, Upper Marlboro, Maryland

May 20, 1965, U.S.A.

James George, Maryland, Upper Marlboro, Maryland

Box 1738, Upper Marlboro, Maryland

May 20, 1965, U.S.A.

James George, Maryland, Upper Marlboro, Maryland

Box 1738, Upper Marlboro, Maryland

May 20, 1965, U.S.A.

James George, Maryland, Upper Marlboro, Maryland

Box 1738, Upper Marlboro, Maryland

May 20, 1965, U.S.A.

James George, Maryland, Upper Marlboro, Maryland

Box 1738, Upper Marlboro, Maryland

May 20, 1965, U.S.A.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16865

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20247

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>4255 Dowerhouse Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>P</u> Last <u>Marshall</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1965</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-1893</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Janitor</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth ? ? ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Raymond Marshall</u>		Address <u>Marlboro, Box 4255 Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> <u>Riverdale, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>12-29-65</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Stewart Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 4 1966</u>	
4001 Benning Road		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

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FOR STATE  
HEALTH DEPT.

Items 18&21 Film G372 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16866 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 20248									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale DOA c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum d. STREET ADDRESS 5801 Sargent Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Frances Isabelle Maske			4. DATE OF DEATH 12 10 1965						
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-14-11		9. AGE (In years last birthday) 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Brogan					14. MOTHER'S MAIDEN NAME Isabelle Gardner				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 577 05 5373		17. INFORMANT Carl V Maske		Address Chillum, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholism 3120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe M.D.					22. DATE SIGNED 12-11-65				
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland					Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec 14, 1965		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City, town or county) (State) Washington D. C.		
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DEC 16 1965		25b. REGISTRAR'S SIGNATURE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16887 Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100									
CERTIFICATE OF DEATH									
Item #4 Film #G372 12/28/65 pc									
1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D O A		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial					d. STREET ADDRESS 820 West Street.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD T. MATTHEWS		4. DATE OF DEATH Month Day Year 12 11 19 65		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 16, 1898		9. AGE (In years, birthday) 67 yrs.		10. UNDER 1 YEAR Months Days 6 7		11. UNDER 24 HRS. Hours Min. 6 7		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Govt.		11. BIRTHPLACE (County & State, or foreign country) Howard Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Matthews					14. MOTHER'S MAIDEN NAME Laura Hebron				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Margaret Matthews: Item # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY THROMBOSIS DUE TO (b) CORONARY SCLEROSIS DUE TO (c) CARCINOMA R. LUNG								INTERVAL BETWEEN ONSET AND DEATH 1 wk - 10 yrs 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)		21. I certify that (I) (this hospital) attended the deceased from 3/10, 1961, to 12/14, 1965, that (I) (we) last saw the deceased alive on 12/10, 1965, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE J M Warren		22b. DATE SIGNED 12/13/65		22c. PHYSICIAN'S NAME (Type) J M WARREN		22d. ADDRESS Laurel Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-16-65		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial,		23d. LOCATION (City, town or county) (State) Laurel, Md.			
24. FUNERAL DIRECTOR Robert L. Sorden		24a. ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DEC 20 1965		25b. REGISTRAR'S SIGNATURE Charles Judge			

Bernard T. Matthews

Carcinoma R. Lung  
Carcinoma Scleros  
Carcinoma Thrombosis

Pneumitis

J. M. Warren

1/11/11  
1/11/11  
1/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16868 CERTIFICATE OF DEATH 20250											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 hr. 50 mins		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X College Park					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 9014 Rhode Island Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Matthew RAYMOND McIntyre			First Middle Last			4. DATE OF DEATH December 7 1965			Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/3/01		9. AGE (in years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY District of Columbia		11. BIRTHPLACE (County & State, or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John H. McIntyre						14. MOTHER'S MAIDEN NAME Gola Anna Reynolds					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS RUTH C. McINTYRE		Address SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) crown pneumonia myocardial infarction										INTERVAL BETWEEN ONSET AND DEATH 5 hrs 5 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 7, 1965 to Dec 7, 1965 that (I) (we) last saw the deceased alive on 12/7 1965, and that death occurred at 4:00 PM, from the causes and on the date stated above.											
22a. SIGNATURE Dr. Leon R. Levitsky						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/7/65			
22c. PHYSICIAN'S NAME (Type) Dr. Leon R. Levitsky						22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-11-1965		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City, town or county) (State) BLADENSBURG, MARYLAND					
24. FUNERAL DIRECTOR W. W. Chambers, Co. Riverdale, Md						25a. REC'D BY REGISTRAR DEC 9 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



10322

10322

Prince George's General Hospital  
Cheverly  
1 hr. 30 min.

Prince George's General Hospital

2010 Rhode Island Avenue

Attention: Laboratory

2101

Main

NO  
The following is a list of the specimens received from the  
laboratory of the Prince George's General Hospital, Cheverly,  
Maryland, on the 10th day of November, 1955.  
The specimens were received from the laboratory of the  
Prince George's General Hospital, Cheverly, Maryland,  
on the 10th day of November, 1955.

10322  
2010 Rhode Island Ave., Prince George's, Md.  
10322  
10322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																
16869					CERTIFICATE OF DEATH					20251						
1. PLACE OF DEATH a. COUNTY P.G.C. MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY PG											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairmont Hgts.											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General					d. STREET ADDRESS 727 61st Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Baby Boy McNeill			First Middle Last		4. DATE OF DEATH 12 10 19 65		Month Day Year									
5. SEX male		6. COLOR OR RACE C.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 8 65		9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. 2				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Cheverly, Maryland			12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME JOSEPH YOUNG					14. MOTHER'S MAIDEN NAME FRANCES McNeill											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. N/A		17. INFORMANT Hospit 1 Records			Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis (cause undetermined) 7620 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 12/8/65, 19 to 12/10, 19 65, that (I) (we) last saw the deceased alive on 12/10 19 65, and that death occurred at 9:50 PM, from the causes and on the date stated above.																
22a. SIGNATURE Thomas A. Christensen M.D.					22b. DATE SIGNED 12/13/65											
22c. PHYSICIAN'S NAME (Type) Thomas A. Christensen, M.D.			22d. ADDRESS 6905 Baltimore Ave. College Park, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF Dec. 17, 1965		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park Cem			23d. LOCATION (City, town or county) (State) LANDOVER, MARYLAND								
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland					25a. REC'D BY REGISTRAR DEC 20 1965		25b. REGISTRAR'S SIGNATURE Charles Judge									

5-148253

100251

100251

Principal elements (see underlined)

James A. Christensen, M.D., 100251

100251, 100251, 100251, 100251

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film G372 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> d. STREET ADDRESS <u>4425 Arnold Road, Apt. T-2</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY in 1b <u>DOA</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Andrews Air Force Base Hospital</u>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Elizabeth Mary McQuaide</u>				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>16</u> Year <u>1965</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 June 1917</u>		9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't. Personnel</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Clarence G. McQuaide</u>						14. MOTHER'S MAIDEN NAME <u>Helen Mc Cune</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>*****</u>		17. INFORMANT <u>Eleanor McQuaide, 3726 Conn. Ave, Wash, DC</u> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>From first and second degree burns of 90% of body surface</u> (c) <u>And acute alcoholism</u>										INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in bathtub of hot water</u>							
20c. TIME OF INJURY Month, Day, Year <u>abt. 5 p.m. 12/16/65</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Suitland Pr. Geo. Md.</u>		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Kehoe</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12-17-65</u>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>12/20/65</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) <u>Suitland, Md.</u>		(State)	
23. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				ADDRESS <u>5130 Wisconsin Ave, NW, Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DEC 23 1965</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

THE UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF MEDICAL SERVICE  
WASHINGTON, D. C.

REPORT OF THE CHIEF OF MEDICAL SERVICE  
ON THE MEDICAL SITUATION IN THE  
ARMY OF THE UNITED STATES  
FOR THE YEAR 1917

THE CHIEF OF MEDICAL SERVICE  
GENERAL MEDICAL OFFICER  
OFFICE OF THE CHIEF OF MEDICAL SERVICE  
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

16871

20253

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East Riverdale, Md.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X East Riverdale, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5417 56th place Apartment 201		e. STREET ADDRESS 5417 56th Place	
3. NAME OF DECEASED (Type or print) First Middle Last Maurice Mc Sweeney		4. DATE OF DEATH Month Day Year Dec 19, 19 65	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 16, 1888
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Electrician	
11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Daniel Mc Sweeney		14. MOTHER'S MAIDEN NAME Nora Horan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 051 07 7894	
17. INFORMANT Nora Mc Sweeney		Address East Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5271 CON PULMONALE DUE TO (b) EMPHYSEMA DUE TO (c) 30 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0021 PULMONARY TUBERCULOSIS		INTERVAL BETWEEN ONSET AND DEATH 2-340 30 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY, 1962, to, 19, that (I) (we) last saw the deceased alive on DEC-11 1965, and that death occurred at 8:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE ALBERT ROTH		22b. DATE SIGNED 12-20-65	
22c. PHYSICIAN'S NAME (Type) ALBERT ROTH		22d. ADDRESS 549 RIVERDALE RD, RIVERDALE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 22, 1965	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town or county) (State) Wheaton, Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DEC 27 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge			



20524

CERTIFICATE OF DEATH

1952

STATE DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16872 CERTIFICATE OF DEATH 20254									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel 13X-2				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital					d. STREET ADDRESS 35 Ev-Mar Mobile Village			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Evelyn		First Middle Last Rose Messenger		4. DATE OF DEATH December 31, 1965		Month Day Year			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-17-21		9. AGE (In years last birthday) 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Clarence Reed					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Husband/Medical Record			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 3 DAY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12-28, 1965, to 12-31, 1965, that (I) (we) last saw the deceased alive on 12-30 1965, and that death occurred at 7:30 AM, from the causes and on the date stated above.									
22a. SIGNATURE C. J. Houmann					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 12-31-65	
22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D.					22d. ADDRESS 4404 Queensbury Road, Riverdale, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE, THEREOF 12/31/65		23c. NAME OF CEMETERY OR CREMATORY Bartlett Funeral Home		23d. LOCATION (City, town or county) Gafton West Va.		(State)	
24. FUNERAL DIRECTOR 7. Haeckis 4739 Balt Ave, Hyattsville, Md.					25a. REC'D BY REGISTRAR JAN 5 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

MEDICAL CERTIFICATION

1992

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

1  
FOR STATE  
HEALTH DEPT.

16873

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20255

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN ID DOA	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 108 E. Braddock Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last James Nicholas Miles		4. DATE OF DEATH Month Day Year 12 4 19 65	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Dec., 1922
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Power Lineman		11b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Miles	
14. MOTHER'S MAIDEN NAME Mary Gladys Barbour		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW II and Korea	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Betty Miles	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade 8234 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of left ventricle (c) Fracture of left 4th rib and sternum Trauma-auto accident		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which ran off road and hit pole	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4:20 a.m. 12 4 19 65		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Rt 495 nr st rt. 410, P.G.,		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale		22. DATE SIGNED 12-4-65	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/1965	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington Co. Va.	
24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home Alexandria, Va.		25a. REC'D BY REGISTRAR DEC 7 1965	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

15873

DEC 1965

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL CERTIFICATION

## 20256

16874

1. <b>PLACE OF DEATH</b> a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
Prince George's		Cheverly		DOA		Prince George General Hospital	
3. <b>NAME OF DECEASED</b> (Type or print)		First		Middle		Last	
Willie		C.		Moore			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		30 May 1902	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
IRON WORKER		UNION IRON WORKS		MISSISSIPPI		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
DANIEL MOORE		BERNARD GORE		YES		1920-1924	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		20. SOCIAL SECURITY NO.		21. INFORMANT	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure		4200		578 013624		BERTHA B. MOORE	
DUE TO		Arteriosclerotic heart disease		DUE TO		SAME AS #2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		23. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. TIME OF INJURY		26. INJURY OCCURRED		27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town)	
Month, Day, Year		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		29. (County)		(State)	
Hour a.m.		19		30. (City or town)		(State)	
p.m.		20		31. (City or town)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		John Kehoe, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12-13-65	
EXAMINER'S NAME (Type)		John Kehoe, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22. BURIAL, CREMATION, REMOVAL (Specify)		23. DATE THEREOF		24. NAME OF CEMETERY OR CREMATORY		25. LOCATION (City, town, or county)	
BURIAL		14 DEC 1965		ARLINGTON NATIONAL		ARLINGTON, VIRGINIA	
26. FUNERAL DIRECTOR		27. ADDRESS		28. REC'D BY REGISTRAR		29. REGISTRAR'S SIGNATURE	
W.W. Chambers Co		Riverdale, Md		DEC 15 1965		John Kehoe	

DEC 15 1965  
DATE



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

1933

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16875  
CERTIFICATE OF DEATH  
20257

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Md. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Magnolia Gardens Nursing Home Lanham, Md.				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood, Md. d. STREET ADDRESS 4218 - 37th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Minnie Morrison 4. DATE OF DEATH Dec. 29 1965				5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 18, 1879 9. AGE (in years last birthday) 86 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence Jones				14. MOTHER'S MAIDEN NAME Mollie Beard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 422-12-1728		17. INFORMANT Mr. Hubert Morrison (above address)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral thrombosis (Son) DUE TO cerebral arteriosclerosis (b) DUE TO generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 16, 1964, to Dec 29, 1965, that (I) (we) last saw the deceased alive on Dec 23, 1965, and that death occurred at 10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Don B. Cameron M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-29-65	
22c. PHYSICIAN'S NAME (Type) DON B. CAMERON				22d. ADDRESS PERRY ST. MT. RAINIER MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12/31/65		23c. NAME OF CEMETERY OR CREMATORY Live-Oak Cemetery		23d. LOCATION (City, town or county) (State) Crenshaw County, Ala.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

652

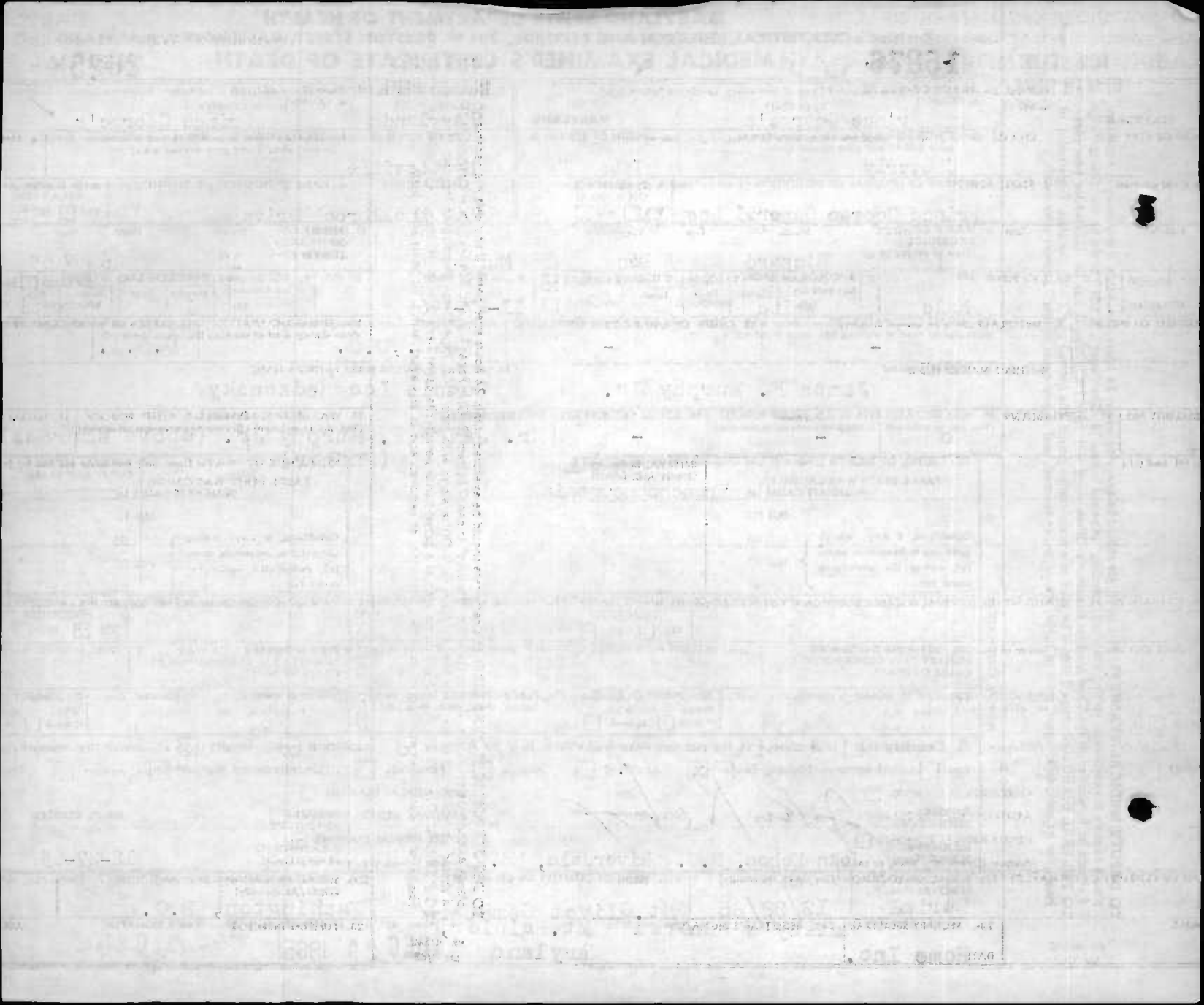
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16876

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 20258

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in lb DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Hyattsville d. STREET ADDRESS 5907 Knollbrook Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Allen Murphy		4. DATE OF DEATH Month Day Year 12 26 19 65	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1965
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) yrs. 1 IF UNDER 1 YEAR Months Days Hours Min. 1 19 65
11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James F. Murphy Jr.		14. MOTHER'S MAIDEN NAME Bonnie Lee Redzensky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr. James F. Murphy Jr. (above address) (Father)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DATE SIGNED 12-27-65	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/28/65	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		24a. REC'D BY REGISTRAR DEC 29 1965 24b. REGISTRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN b <b>2 days</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>South Carolina</b>		b. COUNTY <b>77X-3</b>	
3. NAME OF DECEASED (Type or print) <b>Evelyn Nesbitt</b>		4. DATE OF DEATH <b>Dec. 20 19 65</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>28 April 1895</b>		9. AGE (In years last birthday) <b>70 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Parris VanDyke Smalls</b>		14. MOTHER'S MAIDEN NAME <b>Annie Singleton</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sadye Geneva Nesbitt - daughter, So. Car.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure Sec. BASTED</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteritis mellitus</b> DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>4:25 AM</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Rosa L. Barlin M.D.</b>		22b. DATE SIGNED <b>Dec. 20, 1965</b>		22c. PHYSICIAN'S NAME (Type) <b>Rosa L. Barlin, M.D.</b>		22d. ADDRESS <b>Prince George's Genl Hosp. Cheverly Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE THEREOF <b>12-21-65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fieldings Funeral Home</b>		23d. LOCATION (City, town or county) (State) <b>Charleston, South Carolina</b>		24. FUNERAL DIRECTOR <b>ALEX S. POPE</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1965</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>		25d. REGISTRAR'S ADDRESS <b>414 15th SE Wash., D.C.</b>		25e. REGISTRAR'S PHONE NO.		25f. REGISTRAR'S FAX NO.	

MEDICAL CERTIFICATION



7532

5-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-

*[Faint, illegible handwritten text]*

Robert B. Taylor

2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
20260										
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 13 days						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General					d. STREET ADDRESS 3609 Monroe St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John D. O'Hearn			First Middle Last		4. DATE OF DEATH Dec. 4 1965		Month Day Year			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 7 78		9. AGE (In years last birthday) 87 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER				10b. KIND OF BUSINESS OR INDUSTRY PRINTER		11. BIRTHPLACE (County & State, or foreign country) LOWELL, MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN O'HEARN					14. MOTHER'S MAIDEN NAME ELLEN CROWLEY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT JOHN D. O'HEARN			Address 5609 MONROE ST. HYATTSVILLE, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Pulmonary Edema (b) Congestive failure (c) A.S.H.D. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I (this hospital) attended the deceased from Nov. 21, 1965, to Dec. 4, 1965, that I (we) last saw the deceased alive on Dec. 4, 1965, and that death occurred at 5:40 M, from the causes and on the date stated above.										
22a. SIGNATURE Dr. Barry Rosenberg							22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Barry Rosenberg					22d. ADDRESS CHEVERLY, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 12-7-1965		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (city, town or county) (State) SILVER SPRING, MD.			
24. FUNERAL DIRECTOR W. W. Chamber Co. Rindole, Md.					25a. REC'D BY REGISTRAR DEC 7 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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Princess George

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16879

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20261

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1D <b>10 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Martha G Payne</b>			4. DATE OF DEATH Month Day Year <b>December 10 19 65</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1898</b>		9. AGE (In years last birthday) <b>67 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>D C.</b>	
13. FATHER'S NAME <b>Benjamin Gover</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Lee</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577 26 1039</b>		17. INFORMANT <b>Raymond T. Payne</b>	
				Address <b>3520 Duke st</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure, acute in chronic with uremia</b> 6000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Pyelonephritis, chronic</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>5 yrs</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>12/10</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12/10</b> 19 <b>65</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Peter Duus</b>				22b. DATE SIGNED <b>Dec. 10, 1965</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter Duus, M.D.</b>				22d. ADDRESS <b>6124 Central Ave. Capitol Heights, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-14-65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cem.</b>	
				23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		ADDRESS <b>300 4th St. N. E.D.E.C 15 1965</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
				25b. REGISTRAR'S SIGNATURE	

9598

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16880 CERTIFICATE OF DEATH 20262

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly	
c. LENGTH OF STAY IN 1b 13 hr		d. STREET ADDRESS 6423 Landover Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles H Phillips		4. DATE OF DEATH Month Day Year Dec., 12 1965	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Feb., 1908
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (County & State, or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Horatio Phillips		14. MOTHER'S MAIDEN NAME Nellie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -- nO	
17. INFORMANT Address Jennie R Phillips Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Occlusion (anterior descending) DUE TO (c) Coronary Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 11, 1965, to December 12, 1965, that (H) (we) last saw the deceased alive on December 12, 1965, and that death occurred at 7:35 AM, from the causes and on the date stated above.			
22a. SIGNATURE Frederick H. Henry Wilhelm M.D.		22b. DATE SIGNED December 13 1965	
22c. PHYSICIAN'S NAME (Type) Frederick Henry Wilhelm, M.D.		22d. ADDRESS 6319 Landover Road; Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 14, 1965	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE DEC 16 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 16881 CERTIFICATE OF DEATH 20263											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>Forestville</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>				c. LENGTH OF STAY IN 1b <b>X</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>				d. STREET ADDRESS <b>3429 80th Ave, North</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Forestville Nursing Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Addie</b> First <b>Elsie</b> Middle <b>Pickett</b> Last			4. DATE OF DEATH <b>Dec. 31</b> Month <b>19 65</b> Day Year								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED XX</b> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 14, 1889</b>		9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George Marshall</b>						14. MOTHER'S MAIDEN NAME <b>Mary Allen</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Frances Pickett</b>			Address <b>Same as #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Circulatory Failure 4 hrs</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A.S.H.D. &amp; Coronary Insufficiency</b> (c) <b>Generalized Arteriosclerosis &amp; Small Brain Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July, 1965</b> to <b>Dec 31, 1965</b> , that (I) (we) last saw the deceased alive on <b>Dec 31, 1965</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Kelvin L. Minchin</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/31/65</b>			
22c. PHYSICIAN'S NAME (Type) <b>KELVIN L. MINCHIN M.D.</b>						22d. ADDRESS <b>7200 MAKL BORO PINE SE</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/4/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Natl. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>J. Wm. Lees Sons, Washington D. C.</b>						300 4th St., NE					

10000

10000

CERTIFICATE OF DEATH

NOTARY PUBLIC

STATE OF TEXAS

COUNTY OF DALLAS

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM  
5M 1/63

<div> <div>2</div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>20264</div> <div>2</div> </div>											
<div> <div>16882</div> <div>2</div> </div> <div> <div>20264</div> <div>2</div> </div>											
<div> <div>16882</div> <div>2</div> </div> <div> <div>20264</div> <div>2</div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>803 Berkshire Drive</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u> d. STREET ADDRESS <u>803 Berkshire Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Herbert Edward Pollock</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant (Owner)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Radio &amp; TV Shop</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>						<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>22</u> Year <u>1965</u> 8. DATE OF BIRTH <u>4 Aug. 1904</u> 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
<b>13. FATHER'S NAME</b> <u>Logis Pollock</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes Army-WWII</u> <b>16. SOCIAL SECURITY NO.</b> <u>4200</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Kellman</u> <b>17. INFORMANT</b> <u>Sarah Pollock</u> Address <u>Chillum, Md. 803 Berkshire Rd.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4200</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <u>John Kehoe</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME</b> (Type) <u>John Kehoe, M.D., Riverdale, Md.</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>12/24/65</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat. Cem.</u> <b>22d. LOCATION (City, town, or county) (State)</b> <u>Arlington, Virginia</u>											
<b>23. FUNERAL DIRECTOR</b> <u>B. Danzansky &amp; Sons</u> ADDRESS <u>3501 14th St., N. W.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>DEC 27 1965</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

1945

MEDICAL EXAMINER'S REPORT ON DEATH

Marion (Dorothy)

Louis Pellock

Radio & TV Shop

Andrew Pellock

5-14-45

Yes

AMERICAN

11-11-45

11-11-45

*[Handwritten signature]*

11-11-45

11-11-45

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> <span>16883</span> <span>Item #11 Film #371 12/15/65 pc</span> <span>20265</span> </div>											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>21 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cedar Heights</b> d. STREET ADDRESS <b>913 62nd Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Benjamin F Porter</b>						4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>19 65</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 2, 1900</b>		9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>John Porter</b>						14. MOTHER'S MAIDEN NAME <b>Mary Young</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>579-28-3897</b>		17. INFORMANT <b>Mary Porter</b> Address <b>Same as 2D</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>1539</b> DUE TO (b) <b>male grand arteriosclerosis</b> (c) <b>male grand arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 11</b> , 19 <b>65</b> , to <b>Dec. 2</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec. 2</b> , 19 <b>65</b> , and that death occurred at <b>9:45 M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Don B. Cameron</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> am 22b. DATE SIGNED <b>12-2-65</b>											
22c. PHYSICIAN'S NAME (Type) <b>Dr. Don B. Cameron</b>						22d. ADDRESS <b>3503 Perry St., Mt. Rainier, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <b>12-7-65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Highland Park Md</b>			
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Sons</b>						ADDRESS <b>4925 Denic Ave NE.</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1965</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



John Porter  
Landscape Construction  
219-22-8871 May Porter Lane no 20  
Unknown

VR A15 (4)  
2DM 1/65



MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 602 Main Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby		Middle Girl		Last Powell		4. DATE OF DEATH Month December		Day 28	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 27, 1965		9. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Melvin					14. MOTHER'S MAIDEN NAME Cheryl Elizabeth America				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7625 IMMEDIATE CAUSE (a) Atelectasis both lungs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity. (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 27, 1965, to Dec. 28, 1965, that (I) (we) last saw the deceased alive on Dec. 28, 1965, and that death occurred at 9:15 PM, from the causes and on the date stated above.									
22a. SIGNATURE Thomas A. Christensen, M.D.					22b. DATE SIGNED Dec. 28, 1965		22c. PHYSICIAN'S NAME (Type) Thomas A. Christensen, M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation					23b. DATE THEREOF 1/8/66		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hosp.		
24. FUNERAL DIRECTOR William A. Parker					23d. LOCATION (City, town or county) Cheverly, Maryland		23e. REC'D BY REGISTRAR JAN 12 1966		
23f. REC'D BY REGISTRAR JAN 12 1966					23g. REGISTRAR'S SIGNATURE Charles Judge				

10000

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STATE OF NEW YORK

James C. ...

James C. ...

James C. ...

James C. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>												
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevdrlly</b> c. LENGTH OF STAY IN 1b <b>25 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Washington D.C.</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>522 Decater St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>Zdenek</b>			<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>10</b> Year <b>19 65</b>		<b>5. SEX</b> <b>Male</b>			<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
<b>8. DATE OF BIRTH</b> <b>May 6, 1891</b>			<b>9. AGE</b> (In years last birthday) <b>74</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months _____ Days _____		<b>11. IF UNDER 24 HRS.</b> Hours _____ Min. _____		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Baker</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Czechoslovakia</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country)			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Unknown Ptacek</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Unknown</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)			<b>16. SOCIAL SECURITY NO.</b> (If yes give war or dates of service)		<b>17. INFORMANT</b> <b>Amelia E. Ptacek</b>			<b>Address</b> <b>522 Decatur Street</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema, Severe, Bilateral</b> 4201 CONDITIONS, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary embolism</b> DUE TO (c) <b>Myocardial infraction and fibrosis, massive</b> <b>Arteriosclerotic heart disease</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part II of Item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from _____, 19 <sup>58</sup>, to <sup>12/9</sup>, 19 <sup>65</sup>, that (I) (we) last saw the deceased alive on <sup>12/9</sup>, 19 <sup>65</sup>, and that death occurred at _____ M, from the causes and on the date stated above.</b>												
<b>22a. SIGNATURE</b> <i>Peter Duus</i>										<b>22b. DATE SIGNED</b> <b>Dec. 10, 1965</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Peter Duus, M.D.</b>					<b>22d. ADDRESS</b> <b>6124 Central Ave. Capitol Heights, Md.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>12-13-65</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>			<b>23d. LOCATION</b> (City, town or county) <b>Suitland</b>		<b>(State)</b> <b>Maryland</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Wilhelm Funeral Home</b>					<b>ADDRESS</b> <b>4308 Suitland Rd</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 15 1965</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
<div style="display: flex; justify-content: space-between;"> <span><b>16886</b></span> <span>Item #9 Film #G372 1/4/66 ps</span> <span>20267</span> </div>									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>					c. LENGTH OF STAY IN 1b <b>MARYLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Ethel</b>			First Middle Last <b>Railton</b>			4. DATE OF DEATH Month Day Year <b>December 28, 1965</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-10-1878</b>		9. AGE (in years last birthday) <b>86/87 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Ballingal Railton</b>					14. MOTHER'S MAIDEN NAME <b>Fleming, Dethia</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Medical Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GEN. ARTERIOSCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> UNKNOWN									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>16 DEC.</b> , 19 <b>65</b> , to <b>28 DEC.</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>27 DEC.</b> 19 <b>65</b> , and that death occurred at <b>7:30</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <b>C. J. Houmann</b>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>28 DEC. 1965</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. J. Houmann, M. D.</b>				22d. ADDRESS <b>4404 Queensbury Road, Riverdale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Dec 28, 1965</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 30 1965</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. CDUNITY <i>Prince George</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphia</i>			c. LENGTH OF STAY IN 1b <i>2 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Mt. Rainier</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Saint Branch Nursing Home</i>					d. STREET ADDRESS <i>4017 - 31st St.</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED First <i>MARY</i> Middle <i>Rice</i> Last <i>Rice</i> (Type or print) <i>MADELINE</i> <i>4221-727</i>					4. DATE OF DEATH Month <i>12</i> Day <i>17</i> Year <i>1965</i>					
5. SEX <i>Female</i>		6. COLOR OF RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-15-1888</i>		9. AGE (In years last birthday) <i>75</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Hollywood, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>			
13. FATHER'S NAME <i>George W. Latham</i>					14. MOTHER'S MAIDEN NAME <i>Annie Burroughs</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. J. Russell Rice (above address)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c) <i>18 yrs.</i>					INTERVAL BETWEEN ONSET AND DEATH <i>6 hr.</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Severe cryptic arthritis</i>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <i>Dr. (this hospital)</i> attended the deceased from <i>4-8</i> , 19 <i>64</i> , to <i>12-17</i> , 19 <i>65</i> , that <i>Dr. (we)</i> last saw the deceased alive on <i>12-15</i> , 19 <i>65</i> , and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.										
22a. SIGNATURE <i>R.D. Bauer M.D.</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>12-18-65</i>		
22c. PHYSICIAN'S NAME (Type) <i>R.D. Bauer, M.D.</i>					22d. ADDRESS <i>2513 Buckle Lodge Rd. Adelphia, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/20/65</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cem.</i>			23d. LOCATION (City, town or county) (State) <i>Colmar Manor, Md.</i>			
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>					ADDRESS <i>Mt. Rainier Maryland</i>		25a. REC'D BY REGISTRAR <i>DEC 22 1965</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

15577  
DATE OF BIRTH  
DATE OF DEATH

George A. Taylor  
1878 - 1945  
11-17-1878  
11-17-1945

Female  
1878 - 1945  
11-17-1878  
11-17-1945

George A. Taylor  
1878 - 1945  
11-17-1878  
11-17-1945

Female  
1878 - 1945  
11-17-1878  
11-17-1945

George A. Taylor  
1878 - 1945  
11-17-1878  
11-17-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

16888

20269

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville,</b> d. STREET ADDRESS <b>4217 Jefferson Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Roy Plympton Ridley</b>			4. DATE OF DEATH <b>Month Day Year</b> <b>12/ 9 1965</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>8/3/15</b>		
9. AGE (In years last birthday) <b>50 yrs.</b>			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Ridley, Vinton</b>			14. MOTHER'S MAIDEN NAME <b>Florence</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>Medical Records.</b>		
17. INFORMANT <b>Medical Records.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1621</b> DUE TO <b>BRONCHOGENIC CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 MOS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>18 AUG.</b> , 19 <b>65</b> , to <b>9 DEC.</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>9 DEC</b> 19 <b>65</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>C. J. HOUHMANN</b>			22b. DATE SIGNED <b>10 DEC 1965</b>		
22c. PHYSICIAN'S NAME (Type) <b>C. J. HOUHMANN</b>			22d. ADDRESS <b>RIVERDALE MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Dec 13, 1965</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>			25a. REC'D BY REGISTRAR <b>DEC 16 1965</b>		
ADDRESS <b>Hyattsville, Md.</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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1965

1. The purpose of this report is to provide a summary of the results of the study conducted during the period from January 1, 1965, to December 31, 1965.

2. The study was conducted in accordance with the procedures outlined in the research plan submitted to the National Science Foundation on January 1, 1965.

3. The results of the study are presented in the following sections: (a) Summary of the data collected; (b) Analysis of the data; (c) Conclusions drawn from the data.

4. The data collected during the study are summarized in Table 1, which shows the number of observations made at each of the ten stations during the period from January 1, 1965, to December 31, 1965.

5. The analysis of the data indicates that there is a significant correlation between the number of observations made at each station and the number of observations made at the other stations.

6. The conclusions drawn from the data are that the study has provided a comprehensive overview of the results of the study and that the data collected during the study are consistent with the results of previous studies.

7. The study has provided a comprehensive overview of the results of the study and that the data collected during the study are consistent with the results of previous studies.

8. The study has provided a comprehensive overview of the results of the study and that the data collected during the study are consistent with the results of previous studies.

9. The study has provided a comprehensive overview of the results of the study and that the data collected during the study are consistent with the results of previous studies.

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21. The study has provided a comprehensive overview of the results of the study and that the data collected during the study are consistent with the results of previous studies.

22. The study has provided a comprehensive overview of the results of the study and that the data collected during the study are consistent with the results of previous studies.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

16889

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20270

1. PLACE OF DEATH a. COUNTY Prince George's same as in 2 MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X University Park d. STREET ADDRESS 4104 Woodberry Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park		e. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) home - same as in 2					
3. NAME OF DECEASED (Type or print) Charles D Riefkin		4. DATE OF DEATH Dec. 21 19 65			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1903	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY MANAGEMENT ENGINEERING		11. BIRTHPLACE (State or foreign country) Kentucky	
13. FATHER'S NAME ISAAC RIEFKIN		14. MOTHER'S MAIDEN NAME ANNA LUKOWSKY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 400 228806		17. INFORMANT DOROTHY B. RIEFKIN Address SAME AS # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary infarct 463X DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary embolus (a), stating the underlying cause last. (c) Thrombophlebitis of legs					INTERVAL BETWEEN ONSET AND DEATH days 3 weeks 4 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Riverdale, Md. Address (Street, city, town, or county)		DATE SIGNED 12-22-65	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 12-22-1965	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		22d. LOCATION (City, town, or county) (State) BLADENSBURG, MARYLAND	
23. FUNERAL DIRECTOR W.W. Chambers Co. - Riverdale, Md.		24a. REC'D BY REGISTRAR DEC 28 1965		24b. REGISTRAR'S SIGNATURE Charles Judge	





17 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16890

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

20271

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BRANDYWINE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Route 2 Box 277</b>		d. STREET ADDRESS <b>ROUTE 2 BOX 277</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>H</b> Last <b>RIGOR</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>1st</b> Year <b>1965</b>		5. SEX <b>Female</b>									
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 Sept. 1901</b>		9. AGE (in years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>64</b> Days <b>64</b>		IF UNDER 24 HRS. Hours <b>64</b> Min. <b>64</b>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, DC</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>Washington, DC</b>		13. FATHER'S NAME <b>Marshall Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Sara Wykes</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT <b>Ruth E Physioc 6603-Stockton Lane</b>		Address <b>Hyattsville Md</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Days</b> <b>Years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>21 July</b> , 1965, to <b>12 Oct</b> , 1965, that (I) (we) last saw the deceased alive on <b>12 Oct</b> , 1965, and that death occurred at <b>M</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Stephen Kaufmann</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2 Dec 65</b>		22c. PHYSICIAN'S NAME (Type) <b>STEPHEN KAUFMANN, M.D.</b>		22d. ADDRESS <b>USAF HOSPITAL ANDREWS, ANDREWS AF</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Dec. 2-1965</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros</b>		25a. REC'D BY REGISTRAR <b>DEC 3 1965</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		25c. ADDRESS <b>Simmons Bros. 1661-Good Hope Rd SE Wash DC</b>		25d. DATE <b>DEC 3 1965</b>		25e. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		25f. ADDRESS <b>Simmons Bros. 1661-Good Hope Rd SE Wash DC</b>		25g. DATE <b>DEC 3 1965</b>		25h. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		25i. ADDRESS <b>Simmons Bros. 1661-Good Hope Rd SE Wash DC</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
16891 20272																			
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Heights</b> d. STREET ADDRESS <b>5800 L. Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <b>Rosa</b>			First <b>Rosa</b>		Middle <b>Robertson</b>		Last <b>Robertson</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1965</b>										
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 28, 1885</b>		9. AGE (In years last birthday) <b>80</b> yrs.		10. UNDER 1 YEAR Months <b>80</b>		11. UNDER 24 HRS. Days <b>80</b>		12. HOURS <b>80</b>		13. MIN. <b>80</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME <b>Mary F. Coleman</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Florence Brown</b>					Address <b>same</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 18</b> , 19 <b>65</b> , to <b>Dec. 26</b> , 1965, that (I) (we) last saw the deceased alive on <b>Dec. 26</b> , 19 <b>65</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Frank J. Talbot</b> 22c. PHYSICIAN'S NAME (Type) <b>Frank J. Talbot, M.D.</b>															22b. DATE SIGNED <b>12/27/65</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>4307 Branch Ave Marlow Heights Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF <b>12-30-1965</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Me Memorial</b>					23d. LOCATION (City, town or county) (State) <b>7601-Sheriff Rd.</b>				
24. FUNERAL DIRECTOR <b>HOFFMAN FUNERAL HOME</b>										25a. REC'D BY REGISTRAR <b>DEC 30 1965</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Switland</u>				c. LENGTH OF STAY IN 1b. <u>20 Months</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Switland Nursing Home, Inc.</u>						d. STREET ADDRESS <u>1307 "V" St., S.E.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Forrest A. Rodenbaugh</u>						<b>4. DATE OF DEATH</b> <u>Dec. 29, 1965</u>		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9/30/1883</u>			
<b>9. AGE</b> (in years last birthday) <u>82</u> <b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> <b>11. IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>						<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Rodenbaugh</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Cincinnati, Ohio</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>234-16-0421</u> <b>17. INFORMANT</b> <u>Richard Rodenbaugh</u>						<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 442X DUE TO (b) <u>C.V.R. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Gen. Arteriosclerosis</u>					
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b>						<b>20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Diabetes Mellitus</u>					
<b>21. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>22. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)					
<b>23. TIME OF INJURY</b> Month, Day, Year <u>1965</u> <b>24. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				<b>25. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>26. (City or town)</b> (County) (State)			
<b>27. I certify that (I) (this hospital) attended the deceased from</b> <u>1964</u> , <b>19</b> to <u>12-29, 1965</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12/28/65</u> , <b>and that death occurred at</b> <u>12:05 PM</u> <b>from the causes and on the date stated above.</b>											
<b>28. SIGNATURE</b> <u>Bernard F. Katzen, M.D.</u> <b>29. DATE SIGNED</b> <u>12/29/65</u>						<b>30. ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>					
<b>31. PHYSICIAN'S NAME (Type)</b> <u>Bernard F. Katzen, M.D.</u>						<b>32. ADDRESS</b> <u>2645 Naylor Rd., S.E., Wash., D.C.</u>					
<b>33. BURIAL, CREMATION, REMOVAL (Specify)</b>				<b>34. DATE THEREOF</b> <u>12/31/65</u>				<b>35. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>			
<b>36. LOCATION (City, town or county)</b> <u>Switland, Md.</u>				<b>37. (State)</b>				<b>38. FUNERAL DIRECTOR</b> <u>Wilhelm Funeral Home</u>			
<b>39. ADDRESS</b> <u>4308 Switland Rd.</u>				<b>40. REC'D BY REGISTRAR</b> <u>Charles Judge</u>				<b>41. REGISTRAR'S SIGNATURE</b>			
<b>42. DATE</b> <u>JAN 6 1966</u>				<b>43. REGISTRAR'S SIGNATURE</b>							



UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C.

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TO: THE CHIEF OF STAFF  
FROM: THE CHIEF OF STAFF  
SUBJECT: [Illegible]

[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or official communication.]

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FOR STATE HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20274

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Joseph Rothery</u>		4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1965</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1900</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Rothery</u>		14. MOTHER'S MAIDEN NAME <u>Catherine O'Connor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>134-03-5932</u>	
17. INFORMANT <u>Mrs. Eliz. M. Meek (above address)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>345X</u> <u>MULTIPLE SCLEROSIS</u> (Sister) DUE TO (b) <u>20 yrs</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-2-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE THEREOF <u>1/4/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier, Maryland</u>	
25a. REC'D BY REGISTRAR <u>JAN 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #11 Film #G372 12/28/65 pc 20275											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY in 1b 14 days							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chapel Oaks			d. STREET ADDRESS 5313 Addison St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Jesse Ezra Ruffin					4. DATE OF DEATH Month Day Year Dec., 12 19 65						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 Sept. 1888		9. AGE (In years last birthday) 77 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Millen, Georgia			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Jerry Ruffin					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 11/29 1965 to 12/12 1965, that (I) (we) last saw the deceased alive on 12/11 1965, and that death occurred at 4:45 AM, from the causes and on the date stated above.											
22a. SIGNATURE Louis Mendel					22b. DATE SIGNED 12/13/65						
22c. PHYSICIAN'S NAME (Type) C. LOUIS MENDEL					22d. ADDRESS 1410-74th AVE HYATT, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 12-16-65		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park			23d. LOCATION (City, town or county) (State) Ind			
24. FUNERAL DIRECTOR Morris A. Carter & Co.					25a. REC'D BY REGISTRAR DEC 21 1965		25b. REGISTRAR'S SIGNATURE Charles Judge				

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Charles H. Cherry  
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Dr. John Kehoe, Notified and approved

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GREENBELT</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GREENBELT</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2 F. WESTWAY</b>					d. STREET ADDRESS <b>2 F. WESTWAY</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RALPH JOHNSON RUSSELL</b>			First Middle Last		4. DATE OF DEATH Month Day Year <b>Dec. 6, 19 65</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 10, 1896</b>		9. AGE (In years last birthday) <b>69</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>WILLIAM RUSSELL</b>					14. MOTHER'S MAIDEN NAME <b>MARTHA JOHNSON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW 1 177 07 2879</b>		17. INFORMANT Address <b>MABEL B. RUSSELL Same as #2 (wife)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> DUE TO (b) <b>Coronary sclerosis (previous thrombosis on 9-18-65)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Ca. of prostate (radical prostatectomy on 2-16-61)</b>									INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>54</b> , to <b>Dec. 6</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>10-27-19 65</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Hans Wodak</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-6-1965</b>		
22c. PHYSICIAN'S NAME (Type) <b>Hans Wodak, M. D.</b>					22d. ADDRESS <b>Professional Building, Greenbelt, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/9/65</b>		23c. NAME OF CEMETERY OR <del>REMOVAL</del> <b>Restlawn</b>		23d. LOCATION (City, town or county) (State) <b>Cash Valley Md.</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>					25a. REC'D BY REGISTRAR <b>DEC 8 1965</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Accokeek					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital					d. STREET ADDRESS Stone Foot Road					
3. NAME OF DECEASED (Type or print) Lillian Irene Sager					4. DATE OF DEATH 12 28 19 65					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-28-1916		9. AGE (In years last birthday) 47		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender					10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Harking Co. Ohio		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Emanuel A. Ogg					14. MOTHER'S MAIDEN NAME Mary Wilson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Howard Ogg Accokeek, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Myocardial fibrosis (c) DUE TO Hypertensive arteriosclerotic heart disease. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John Kehoe					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DATE SIGNED 12-29-65					
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF Dec. 29, 1965		22c. NAME OF CEMETERY OR CREMATORY Haldeman Funeral Home		22d. LOCATION (City, town, or county) (State) Lancaster, Ohio			
23. FUNERAL DIRECTOR F. Gasch's Sons, 16 Yorkville, Md.					24a. REC'D BY REGISTRAR JAN 3 1966		24b. REGISTRAR'S SIGNATURE J. Charles Judge			

Medical Examination Certificate of State  
No. 1000  
Date of Examination: 10/10/1910  
Name of Examinee: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Occupation: [illegible]  
Place of Birth: [illegible]  
Date of Issue: 10/10/1910  
Signature of Examiner: [illegible]  
Signature of State: [illegible]  
Official Seal: [illegible]

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20279

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>622 Silver Spring Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Thomas Schrider</b>		4. DATE OF DEATH <b>12 23 19 65</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 Jan., 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbing Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
13. FATHER'S NAME <b>John Thomas Schrider</b>		14. MOTHER'S MAIDEN NAME <b>Clara Jane Hutchinson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>215-26-0311</b>	
17. INFORMANT <b>Emma Schrider</b>		Address <b>622 Silver Spring Avenue Silver Spring, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Occlusion of coronary artery</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>  <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>John Kehoe</b> M.D. EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale</b> DATE SIGNED <b>12-25-65</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-27-65</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR <b>Harmer E. Pumphrey, Inc.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 1965</b>	
ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20280

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY St. Marys Co. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) California d. STREET ADDRESS Rt. 2, Box 273		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Philip Barton Shafer Jr.		4. DATE OF DEATH Month 12 Day 27 Year 19 65			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11 Aug. 1954		9. AGE (in years last birthday) 11 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PHILIP BARTON SHAFER SR.		14. MOTHER'S MAIDEN NAME LOUISE TROSSBACH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT MOTHER SAME AS # 2 ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head 9190 DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in back yard of home by accidental discharge of shotgun.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:50 a.m. 12-27-1965		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back yard of home 20f. (City or town) Same as #2 (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-28-65	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Dec. 29, 1965		22c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL GARDENS 22d. LOCATION (City, town, or county) WALDORF, MARYLAND (State)	
23. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		24a. REC'D BY REGISTRAR DEC 30 1965		24b. REGISTRAR'S SIGNATURE J Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN b. <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> d. STREET ADDRESS <u>834 52nd. Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Minnie</u> Middle <u>F.</u> Last <u>Shaw</u>						<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>14</u> Year <u>19 65</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 1885</u>		<b>9. AGE</b> (In years last birthday) <u>80</u> yrs.           IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>at home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Unknown</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>				<b>16. SOCIAL SECURITY NO.</b> (If yes give year or dates of service) <u>  </u>		<b>17. INFORMANT</b> <u>  </u>		<b>Address</b> <u>  </u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <u>Cardiac tamponade</u>            4201            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }            (b) <u>From myocardial infarction</u>            DUE TO            (c) <u>  </u> </div> <div> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>  </u> </div> </div>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Fracture of left humerus and left radius - one week</u>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home.</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>noon</u> p.m. <u>12-7-</u> <u>19 65</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Same as #2</u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>John Kehoe</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>12-16-65</u>			
<b>EXAMINER'S NAME</b> (Type) <u>John Kehoe, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>12-18-65</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington National Scitland Maryland</u>		<b>22d. LOCATION</b> (City, town, or county) <u>  </u>		<b>(State)</b> <u>  </u>	
<b>23. FUNERAL DIRECTOR</b> <u>W. W. Chambers &amp; Co. 517-11th St. S.E.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>DEC 27 1965</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be prepared within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

16901

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

20282

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>Queen Ann Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marshall Bernard Smith</b>			4. DATE OF DEATH Month Day Year <b>December 29 19 65</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug. 13, 1903</b>		9. AGE (In years last birthday) Months Days Hours Min. <b>62 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William Francis Smith</b>			14. MOTHER'S MAIDEN NAME <b>Laura Perrie</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Agnes Louella Smith-</b> Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary edema</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>arteriosclerotic heart disease</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hepatic coma, embolus of liver</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>my</b> (this hospital) attended the deceased from <b>Dec. 17</b> , 19 <b>65</b> , to <b>Dec. 29</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec. 29</b> , 19 <b>65</b> , and that death occurred <b>12:20M</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Don B. Cameron</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Dec. 29, 1965</b>
22c. PHYSICIAN'S NAME (Type) <b>Don B. Cameron, M.D.</b>			22d. ADDRESS <b>3503 Perry St. Mt. Rainier, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/1/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cath Com.</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Ritchie Bros. Upper Marlboro, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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C. A.

\* Upper-Mariyoto, Nda \*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

\*mi 10 osteoarthritis

VR A15 (4)  
20M 1/65

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

16302

20283

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. LENGTH OF STAY IN 1b <b>9 mos., 16 dys.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>236 11th St. N. E.</b>			
3. NAME OF DECEASED (Type or print) <b>Annie T. Stancill</b>				4. DATE OF DEATH <b>Dec. 13 1965</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/15/1881</b>	
9. AGE (in years last birthday) <b>84</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Concord, North Carolina</b>	
13. FATHER'S NAME <b>Frank Stancill</b>				14. MOTHER'S MAIDEN NAME <b>Edna Cox</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>hypertensive cardiovascular disease, cerebrovascular accident with left hemiparesis, remote; chronic pyelonephritis; diabetes mellitus, *</b>						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertensive cardiovascular disease, cerebrovascular accident with left hemiparesis, remote; chronic pyelonephritis; diabetes mellitus, *</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/27/61</b> to <b>12/13</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12/13</b> , 19 <b>65</b> , and that death occurred at <b>1:30 A.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				22b. DATE SIGNED <b>12/13/65</b>		22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>12-21-65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hammonym. Cem</b>		23d. LOCATION (City, town or county) (State) <b>MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Joseph H. Stewart</i>				25a. REC'D BY REGISTRAR <b>DECE 20 1965</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16903

## CERTIFICATE OF DEATH

21284

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> c. LENGTH OF STAY IN 1b <u>3 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL MANOR - 4922 LA SALLE RD</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 47X-3</u> d. STREET ADDRESS <u>BAKERS STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ethel Robeson STERLING</u>		<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>10</u> Year <u>1965</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12-15-72</u>		<b>9. AGE</b> (In years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>WASHINGTON, D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>George Robeson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY AULICK</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> Address <u>Ethel Davidson 2224 Wash. Ave., S.S.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral atherosclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>3d</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma breast</u>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 1962</u> <b>to</b> <u>10 Dec 1965</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1 Dec 1965</u> <b>and that death occurred at</b> <u>11 AM</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Paul T. Noone</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>DEC 16 1965</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Paul T. Noone</u>				<b>22d. ADDRESS</b> <u>5201 Randolph Rd., Rockville, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12-13-65</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gate of Heaven</u>		<b>23d. LOCATION (City, town or county)</b> <u>Silver Spring</u>		<b>(State)</b> <u>Md.</u>			
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph Gawler's Sons, Washington, D.C.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DEC 16 1965</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16904

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

20285

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b> d. STREET ADDRESS <b>507 67th Place, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Otha</b> Middle <b>L</b> Last <b>Sterling, Sr.</b>		4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>19 65</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/16/94</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b>	
11. IF UNDER 24 HRS. Hours <b>1</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>Virginia</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Amelia ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Otha L. Sterling Jr. 8701-Crandall Rd</b>	
17. INFIRMANT <b>Address Lanham, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> 4341 DUE TO (b) <b>thrombophlebitis</b> DUE TO (c) <b>congestive heart failure</b> 8 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 21</b> , 19 <b>65</b> , to <b>Dec. 29</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Dec. 29</b> , 19 <b>65</b> , and that death occurred at <b>12:20</b> a.m., from the causes and on the date stated above.			
22a. SIGNATURE <b>Don B. Cameron</b> M.D.		22b. DATE SIGNED <b>12-29-65</b>	
22c. PHYSICIAN'S NAME (Type) <b>Don B. Cameron, M.D.</b>		22d. ADDRESS <b>3503 Perry St. Mt. Rainier, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 30-1965</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros</b> <b>Simmons Bros.-1661--Good Hope Rd SE Wash DC</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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# 1

## FOR STATE HEALTH DEPT

### MARYLAND STATE DEPARTMENT OF HEALTH

#### Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20287

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				e. STREET ADDRESS <b>1223 48th. Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>Paul Thomas Swank</b>				4. DATE OF DEATH <b>12 5 1965</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 20, 1939</b>	
9. AGE (In years last birthday) <b>26</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co.</b>			
13. FATHER'S NAME <b>William Thomas Swank</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Gonder</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Dorothy Cook</b>				Address <b>Monroeville, Pa. (sister)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing injury of chest</b> <b>8234</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car which ran off road and hit a tree.</b>			
20c. TIME OF INJURY Month, Day, Year <b>3:25pm p.m. 12-5-1965</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Prince Geo. Co., Md.</b>				20f. CITY or town (County) (State) <b>Prince Geo. Co., Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>				22. DATE SIGNED <b>12-6-65</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>				Address (Street, city, town, or county) <b>Riverdale, Md.</b>			
23a. BURIAL, CREMATION, ETC. (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/9/65</b>		23c. NAME OF CEMETERY OR <b>Hill's Church</b>		23d. LOCATION (City, town or county) (State) <b>Westmoreland Co., Pa</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>				25a. REC'D BY REGISTRAR <b>DEC 8 1965</b>			
ADDRESS <b>Hyattsville, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

654

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified by the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

72

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #7 Film #0372 13766											
20288											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 mo-17 da.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Box 1035</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Hammond</b>			First Middle Last <b>Swann</b>			4. DATE OF DEATH Month <b>Dec</b> Day <b>25</b> Year <b>1965</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1879?</b>		9. AGE (In years last birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William Swann</b>						14. MOTHER'S MAIDEN NAME <b>Mary Estep</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Croome, Md.</b> <b>Chesley Swann Bx.3360 Airport Rd.,</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adrenal insufficiency</b> 274X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>65</b> , to <b>12/26</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12/23</b> , 19 <b>65</b> , and that death occurred <b>at 4:00 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Frank J. Talbot, MD.</b>						22b. DATE SIGNED <b>12/27/65</b>					
22c. PHYSICIAN'S NAME (Type) <b>Frank J. Talbot, MD.</b>						22d. ADDRESS <b>4307 Branch Ave Marlow Heights Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-29-65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Methodist</b>				23d. LOCATION (City, town or county) (State) <b>Croome, Md.</b>			
24. FUNERAL DIRECTOR <b>Myrtle K. Rollins 4339 Washington N.E.</b>						25a. REC'D BY REGISTRAR <b>DEC 29 1965</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Mr. Geo.

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George's Hospital

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Frank A. Taylor, Jr.

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HEALTH DEPT.

16507

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20289

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland D.C. b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 5202 Crittenden Street, Bladensburg, Md. 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 658 F St. N.E. 2304 14th St. N.E.			
3. NAME OF DECEASED (Type or print) First Middle Last Ida Mae Talhelm		4. DATE OF DEATH Month Day Year December 19 1965		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-24-18		9. AGE (in years last birthday) 47 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home Maker		11. BIRTHPLACE (State or foreign country) Smithfield, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earl Whoolery		14. MOTHER'S MAIDEN NAME Donna Dancer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 200-01-6828	
17. INFORMANT Sprague Talhelm Jr.		Address 2504 14th St N.E, Wash, DC		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction and Fibrosis 4201 DUE TO (b) Coronary Occlusion, left anterior descending DUE TO (c) Coronary Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED			
ACTUAL SIGNATURE John Kehoe		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) Riverdale, Md.	
EXAMINER'S NAME (Type) John Kehoe		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 23, 1965		23c. NAME OF CEMETERY OR CREMATORY Hopwood Cemetery	
23d. LOCATION (City, town or county) (State) Hopwood, Pennsylvania		24. FUNERAL DIRECTOR Lee FunrHome, 300 4th St NE, Wash, D.C.		25a. REC'D BY REGISTRAR DEC 22 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16908

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

20290

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		d. STREET ADDRESS 301 Plateau Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Adassah Taylor				4. DATE OF DEATH Month Day Year Dec., 13 19 65			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 May 1895	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH SCHIFIELD				14. MOTHER'S MAIDEN NAME SARAH ANN IVES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address HAROLD TAYLOR (HUSBAND) SAME AS \$2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive Heart failure</i> 4200 DUE TO <i>arterio sclerotic Heart disease</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>auricular fibrillation</i> (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of the Cecum with Liver Metastasis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Nov. 17, 19 65, to Dec. 13, 19 65, that (I) (we) last saw the deceased alive on Dec. 13, 19 65, and that death occurred at 6:40 AM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Zouheir Shama</i>				22b. DATE SIGNED Dec. 13, 1965		22c. PHYSICIAN'S NAME (Type) Zouheir Shama, M.D.	
22d. ADDRESS Prince George's Genl. Hosp. Cheverly, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-15-65		23c. NAME OF CEMETERY OR CREMATORY GEORGE WASH. CEMETERY		23d. LOCATION (City, town or county) (State) HYATTSVILLE MD.	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS		24a. REC'D BY REGISTRAR DEC 16 1965		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

Concurrence of the Council with the  
Executive Committee  
Executive Committee  
Executive Committee  
Executive Committee

Executive Committee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b College Park	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Yaroie Last Taylor		4. DATE OF DEATH Month December Day 23 Year 19 65	
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-30
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) North Carolina		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME Charlie Pa Herson		15. MOTHER'S MAIDEN NAME Jessie May Turner	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. SOCIAL SECURITY NO. 16900	
18. INFORMANT Husband/Medical Record		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of h ovary @ metastasis (c) anemia -		INTERVAL BETWEEN ONSET AND DEATH 2 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-14-19 65 to 12-23-19 65, that (I) (we) last saw the deceased alive on 12-23-19 65, and that death occurred at 10:20 PM, from the causes and on the date stated above.			
22a. SIGNATURE R.C. Herman		22b. DATE SIGNED 12-23-65	
22c. PHYSICIAN'S NAME (Type) R. C. Herman, M. D., 4404 Queensbury Road, Riverdale, Maryland		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-29-65		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Harmony mem Park		23d. LOCATION (City, town or county) (State) Hyland Park Md	
24. FUNERAL DIRECTOR H.S.W. Washington + Son 4925 Deane Ave NE		25a. REC'D BY REGISTRAR DEC 29 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE	

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*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

Items 18&21 Film G374 7-66-66  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

20292

1  
**FOR STATE  
 HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b> d. STREET ADDRESS <b>8100 Oxon Hill Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Retha Lorraine Tennyson</b>		4. DATE OF DEATH Month Day Year <b>12 25 19 65</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 June, 1923</b>
9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clifford Hamilton</b>		14. MOTHER'S MAIDEN NAME <b>Daisy ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>James W. Tennyson</b>	
17. INFORMANT <b>Same as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> 9219 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } From aspiration of gastric contents DUE TO (b) <b>From aspiration of gastric contents</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12-25-65</b> Address (Street, city, town, or county)			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 28-65</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery, Arlington</b>		22d. LOCATION (City, town, or county) (State) <b>Virginia</b>	
23. FUNERAL DIRECTOR <b>Simmons Bros.</b> Address <b>1661- Good Hope Rd. SE. Wash., DC.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 1965</b>	
24b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			



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**MARYLAND STATE DEPARTMENT OF HEALTH**

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

20293

1. PLACE OF DEATH a. COUNTY <i>Prince Geo County</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince Geo</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Riverdale, Md</i>		c. LENGTH OF STAY IN 1b <i>16 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Eugene Holand Memorial</i>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville, Md. Apt 102</i>	
f. STREET ADDRESS <i>3900 Hamilton St</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Cassie V. Thomas</i>		4. DATE OF DEATH <i>Dec. 5, 1965</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/19/87</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Daniel PROCTOR</i>		14. MOTHER'S MAIDEN NAME <i>McLEUSA Williams</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>720</i>	
17. INFORMANT <i>4408 Woodbury Rd. Riverdale, Md. Record office</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA TOSIS</i> 1760 OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CARCINOMA OF VULVA</i> OUE TO (c)	
19. INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i> <i>1 1/2 yrs</i>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
23. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		24. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
25. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		26. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
27. 20f. (City or town) (County) (State)		28. 21. I certify that (I) (this hospital) attended the deceased from <i>1 JULY</i> , 1964, to <i>5 DEC</i> , 1965, that (I) (we) last saw the deceased alive on <i>5 DEC.</i> 1965, and that death occurred at <i>10:20</i> P.M. from the causes and on the date stated above.	
29. 22a. SIGNATURE <i>C. J. Houmann</i>		30. 22b. DATE SIGNED <i>6 DEC 1965</i>	
31. 22c. PHYSICIAN'S NAME (Type) <i>C. J. HOUMANN</i>		32. 22d. ADDRESS <i>RIVERDALE MD.</i>	
33. 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		34. 23b. DATE THEREOF <i>12/7/65</i>	
35. 23c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln</i>		36. 23d. LOCATION (City, town or county) (State) <i>Colman Manor Md.</i>	
37. 24. FUNERAL DIRECTOR <i>Francis Rosch Sons Hyattsville, Md.</i>		38. 25a. REC'D BY REGISTRAR <i>DEC 8 1965</i>	
39. 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		40. 25c. REGISTRAR'S NAME <i>Charles Judge</i>	

15/1/52  
Ft. Linc.

250

Colony 250

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16912

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20294

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>7232 Joplin Street</u>	
3. NAME OF DECEASED (Type or print) <u>Clement Alan Thornton</u>		4. DATE OF DEATH <u>12 30 19 65</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-1959</u>
9. AGE (In years lost birthday) <u>6</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>James Leo Thornton</u>	
14. MOTHER'S MAIDEN NAME <u>Marcia</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>James Thornton-7232 Joplin Street</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>8124</u> IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO <u>Fracture of both femora and mandible</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>And laceration of brain</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by car.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>6:55pm</u> 12-30- 19 65		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pleasant, Md.</u> (City or town) (County) (State)		20f. <u>6900 block of George Palmer Highway, Seat</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>12-31-65</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/4/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Stewart Funeral Home 4001 Benning Road,</u> ADDRESS		25a. REC'D BY REGISTRAR <u>NE</u> DATE <u>JAN 5 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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STATE OF NEW YORK

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16913

20295

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY in 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> d. STREET ADDRESS <u>5118 Logan Court</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dorothy L Tucker</u>		4. DATE OF DEATH Month Day Year <u>12 4 19 65</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1906</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>T. Paul Mudd Real Estate Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>Country</u>	
13. FATHER'S NAME <u>Daniel Paton</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Blair</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Albert Blair Tucker 5419- Auth Rd. SE.</u>	
17. INFORMANT <u>Albert Blair Tucker 5419- Auth Rd. SE.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 4201 CONDITIONS, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary artery occlusion</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED	
ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>		22. DATE SIGNED <u>12-6-65</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 7- 1965</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Simmons Brothers</u> ADDRESS <u>1661- Good Hope Rd. SE. Wash. DC</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1965</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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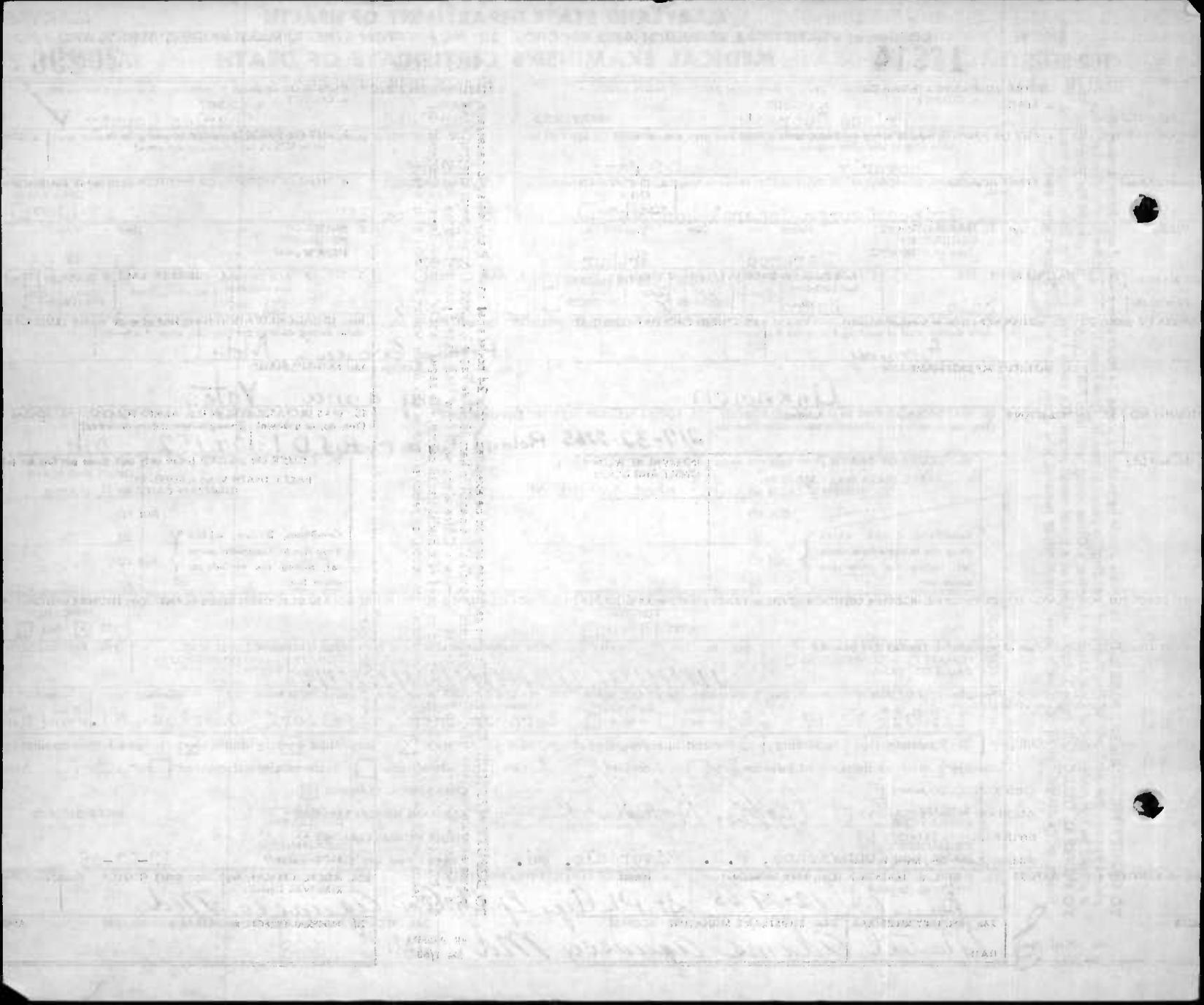
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FOR STATE  
HEALTH DEPT.

Item 20 Film G375 4/ MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16914 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 20296

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles County ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waldorf	
c. LENGTH OF STAY in 1b 8 days		d. STREET ADDRESS BFD 1, Box 152	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Arthur Turner		4. DATE OF DEATH Month 12 Day 25 Year 19 65	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-31-1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prince George's, Md.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Georgianna Yates	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-32-2265	
17. INFORMANT Roland Turner - R.F.D. 1 - Box 152		Address Waldorf, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Gun shot wound of head 919.0 DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 11:00 a.m. 12/17 19 65		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Barn on farm		20f. (City or town) Waldorf (County) Charles (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-65	
22c. NAME OF CEMETERY OR CREMATORY St. Phillips Ep. Ch. Cem.		22d. LOCATION (City, town, or county) Aquasco, Md.	
23. FUNERAL DIRECTOR Martell Adams		24a. REC'D BY REGISTRAR JAN 3 1966	
ADDRESS Aquasco, Md.		24b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Pr. Geo.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. A. Prince George General Hosp.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air -- Bowie</u> d. STREET ADDRESS <u>12102 Maddox Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>EVA</u> Middle <u>L.</u> Last <u>TWILLEY</u>		<b>4. DATE OF DEATH</b> Month <u>Dec.</u> Day <u>7th</u> Year <u>1965</u>	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 24-1895</u>	
<b>9. AGE</b> (In years last birthday) <u>70 yrs.</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> 	
<b>13. FATHER'S NAME</b> <u>Joseph Poe</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Hattie Potter</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <u>A. June Philyaw</u>		<b>Address</b> <u>Same as Item #2</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> (b) <u>Cerebral Thrombosis</u> (c) <u>Cerebral Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, Hypertension, Rheumatoid Arthritis</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June</u> , 19 <u>60</u> , to <u>Dec 5</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 4</u> , 19 <u>65</u> , and that death occurred at <u>9:05</u> M, from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Jack Crowell MD</u>		<b>22b. DATE SIGNED</b> <u>Dec. 7-1965</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Jack Crowell</u>		<b>22d. ADDRESS</b> <u>2025-I-St., N. W. Wash. DC</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Dec. 10-1965</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Suitland, Maryland</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Simmons Bros. 1661-Good Hope Rd SE Wash DC</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 9 1965</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
16916 CERTIFICATE OF DEATH 20298														
1. PLACE OF DEATH a. COUNTY Prince Georges					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland					b. COUNTY Pr. Georges									
c. LENGTH OF STAY IN 1b 8 Days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 70 Suitland Nursing Home, Inc.					d. STREET ADDRESS 4629 Lewis Ave.									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Middle Last Gaetano Vitale					4. DATE OF DEATH December 3, 19 65									
5. SEX m					6. COLOR OR RACE w									
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 11-16-1885									
9. AGE (In years last birthday) 80 yrs.					10. IF UNDER 1 YEAR Months Days									
11. BIRTHPLACE (County & State, or foreign country) Italy					12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Joseph Vitale					14. MOTHER'S MAIDEN NAME Rachel Aversa									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 163-05-3301									
17. INFORMANT Joseph Vitale					Address 2103 Fisher Street Hillcrest Apts., Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure (b) Arteriosclerotic Heart Disease (c) 5 yr. Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia										INTERVAL BETWEEN ONSET AND DEATH 1 week				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1965, to Dec. 3, 1965, that (I) (we) last saw the deceased alive on Dec. 2, 1965, and that death occurred at 7 AM, from the causes and on the date stated above.														
22a. SIGNATURE Frank S. Pellegrini										22b. DATE SIGNED 12.3.65				
22c. PHYSICIAN'S NAME (Type) Frank S. Pellegrini, M.D.										22d. ADDRESS 3611 Branch Ave SE				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 12-6-65				
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill										23d. LOCATION (City, town or county) (State) Suitland Md				
24. FUNERAL DIRECTOR Lee Funeral Home										25a. REC'D BY REGISTRAR DEC 8 1965				
ADDRESS 300-44th St. SE Washington D.C.										25b. REGISTRAR'S SIGNATURE Charles Judge				



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CHIEF IN CHARGE



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

16917

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20299

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 7842 Circle Drive			
3. NAME OF DECEASED (Type or print) Efrosene Efroso G. Vougioukles				4. DATE OF DEATH 12 13 19 65			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1880	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Sparta, Greece				12. CITIZEN OF WHAT COUNTRY? Greece			
13. FATHER'S NAME Vasili Kavokas				14. MOTHER'S MAIDEN NAME Staraula Kavokas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---			
17. INFORMANT Helen L. Mamakas-511-3rd. St. SE DC3				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md.				DATE SIGNED 12-13-65			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/65		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
23. FUNERAL DIRECTOR Jas. T. Ryan, Inc. 317 Pa. Ave., SE DC				24a. REC'D BY REGISTRAR 16 1965 24b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

150

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16918									
20360									
1. PLACE OF DEATH a. COUNTY Prince Georges					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital					d. STREET ADDRESS 5491 Sunnyside Avenue				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Ella - Ellen J.					4. DATE OF DEATH Month 12 Day 7 Year 1965				
5. SEX F					6. COLOR OR RACE W				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 4-9-1883				
9. AGE (In years last birthday) 82 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Devers					14. MOTHER'S MAIDEN NAME -- Fuller				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 578-26-3811				
17. INFORMANT Lovell Mortfeld, Friend/Medical Record					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 5 DEC. 1965, to 7 DEC. 1965, that (I) (we) last saw the deceased alive on 7 DEC. 1965, and that death occurred at 2:45 PM, from the causes and on the date stated above.									
22a. SIGNATURE C.J. Houmann									
22b. DATE SIGNED 7 DEC. 65									
22c. PHYSICIAN'S NAME (Type) C.J. Houmann, M.D.									
22d. ADDRESS 4404 Queensbury Road, Riverdale, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 12-10-65									
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Ceme.									
23d. LOCATION (City, town or county) (State) Arlington, Va.									
24. FUNERAL DIRECTOR ADDRESS 741-11									
25a. REC'D BY REGISTRAR DEC 10 1965									
25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
16919 20301										
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN ID <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Holly Park</b> d. STREET ADDRESS <b>1206 Hill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>William</b>			First Middle Last <b>Washington</b>			4. DATE OF DEATH <b>Dec. 23 19 65</b>		Month Day Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-10-88</b>		9. AGE (In years last birthday) <b>77 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William J. Washington</b>					14. MOTHER'S MAIDEN NAME <b>Catherine UKN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Huntsville, Md. Leo Washington 1206 Hill Rd.,</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 4200 DUE TO <b>Myocardial failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>arteriosclerotic heart disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>acute gastrointestinal bleeding</b>								INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>12-19</b> , 19 <b>65</b> , to <b>12-23</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12-23</b> 19 <b>65</b> , and that death occurred at <b>5:25 PM</b> , from the causes and on the date stated above.										
22a. SIGNATURE <b>Don B. Cameron</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-24-65</b>			
22c. PHYSICIAN'S NAME (Type) <b>DON B. CAMERON</b>					22d. ADDRESS <b>3503 PERRY ST. RAINIER, M.P.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-24-65</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dnt. Olivet</b>		23d. LOCATION (City, town or county) (State) <b>Washington D.C.</b>				
24. FUNERAL DIRECTOR <b>Myrtle K. Rollins</b>					ADDRESS <b>4334 Hunt Pl. NE, Wash., D.C.</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1965</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

16920

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20302

1. PLACE OF DEATH e. COUNTY <b>Prince George MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>9177 Market Lane,</b>		
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Theresa</b> Last <b>Whalen</b>			4. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>1965</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>25 July, 1908</b>		9. AGE (In years last birthday) <b>57 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Galludet College</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Simon J. Shea</b>			14. MOTHER'S MAIDEN NAME <b>Julia Kelly</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Thomas W. Whalen</b> Address <b>9177 Market Lane Greenbelt, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningitis</b> <b>230.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Osteomyelitis of skull</b> (c) <b>DUE TO</b> (e), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH days <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe</b>		M.D. <b>John Kehoe, M.D.</b>		DATE SIGNED <b>12-25-65</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
<b>Burial</b>	<b>12-28-65</b>	<b>Gate of Heaven Cemetery</b>	<b>Silver Spring, Maryland</b>		
23. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>	ADDRESS <b>434 Georgia Avenue Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 4 1966</b>	24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

10-11-54

STATE OF TEXAS  
COUNTY OF DALLAS

DEED  
RECORDED

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[Faint, mostly illegible text and markings across the page, including a large handwritten signature in the lower right quadrant.]																																																																																																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
16921 20303										
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Adelphi			c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Adelphi			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2203 Apache Streett					d. STREET ADDRESS 2203 Apache Streett					
3. NAME OF DECEASED (Type or print) First HENRY Middle CLAY Last Whiteford					4. DATE OF DEATH DEC. 5, 1965					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 26, 1901		9. AGE (In years last birthday) 63 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive					10b. KIND OF BUSINESS OR INDUSTRY Gas Co.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. MORGAN Whiteford					14. MOTHER'S MAIDEN NAME ALICE SCARBOROUGH					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214 01 0316		17. INFORMANT Isabelle S. Whiteford Same as #2 (wife)						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 DUE TO (b) Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 4-1, 1934, to 12-5, 1965, that (I) (we) last saw the deceased alive on 12-3, 1965, and that death occurred at M, from the causes and on the date stated above.										
22a. SIGNATURE A Deitz					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-6-65	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.					22d. ADDRESS Prince George Plaza Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/8/65		23c. NAME OF CEMETERY OR CREMATORIUM SLATEVILLE		23d. LOCATION (City, town or county) (State) Delta, Pa.				
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DEC 8 1965		25b. REGISTRAR'S SIGNATURE J Charles Judge			

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James O. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16922 CERTIFICATE OF DEATH 20304

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Hyattsville</b>		d. STREET ADDRESS <b>5309 38th Avenue Apt. #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frederick</b>		First <b>(nmn)</b>		Middle <b>Williams</b>		Last <b>Williams</b>		4. DATE OF DEATH <b>12 5 19 65</b>		Month <b>12</b>		Day <b>5</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-23-95</b>		9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles L. Williams</b>								14. MOTHER'S MAIDEN NAME <b>Mary Barusick</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 1 577 58 9198</b>				17. INFORMANT Address <b>Marie A. Williams Same as #2 (wife)</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of LUNG</b> <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <b>July 65</b>			
												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>65</b> , to <b>Dec 5</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12-5</b> 19 <b>65</b> , and that death occurred at <b>1:15</b> M, from the causes and on the date stated above.															
22a. SIGNATURE <b>Albert Roth, M.D.</b>								22b. DATE SIGNED <b>12-5-65</b>							
22c. PHYSICIAN'S NAME (Type) <b>Albert Roth, M.D.</b>								22d. ADDRESS <b>5409 Riverdale Rd., Riverdale, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12/9/65</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>			
24. FUNERAL DIRECTOR <b>F. Bosch</b>								25a. REC'D BY REGISTRAR <b>DEC 8 1965</b>				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>23 dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1117 New Jersey Ave. S. E.</b> d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Milton A. Williams</b>			4. DATE OF DEATH <b>Dec. 22 1965</b>			5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <b>Sep. not legally</b>		8. OATE OF BIRTH <b>4.17.1918</b>		9. AGE (in years last birthday) <b>47 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Skilled laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D. C. Sewer Dept.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Macon, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ernest Williams</b>			14. MOTHER'S MAIDEN NAME <b>Anna Adams</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-16-5157</b>		17. INFORMANT <b>Decedent</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. OeATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> <b>0021</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITON GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>8/29/62</b> to <b>12/22 1965</b> , that (I) (we) last saw the deceased alive on <b>12/22 1965</b> , and that death occurred at <b>6:10 P</b> M, from the causes and on the date stated above. 22a. SIGNATURE <b>Moe Weiss</b> 22b. OATE SIGNED <b>12/22/65</b> 22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b> 22d. ADDRESS <b>Glenn Dale Hospital</b> <b>Glenn Dale, Maryland</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs, 4 mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/28/1965</b>		23b. DATE THEREOF <b>12/28/1965</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>LANDOVER MARYLAND</b>			
24. FUNERAL DIRECTOR <b>W. ERNEST JARVIS CO. 1432 YOD ST.</b>				25a. REC'D BY REGISTRAR <b>DEC 28 1965</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

N.D. WASH.

12213

Prince Georges

Class Date (month)

Class Date (month)

Wilson

Sp., not tested

Male

Shiloh, Labrador

James, Virginia

No

178-16-1157

document

Anna, Alaska

D. G. Sawyer, Dept. Marine, Georgia

USA

A. L. 1918

Wilson

Doc.

D. G.

3 years, 1 day

Washington

1117 New Jersey Ave. S. E.

Dr. John Kehoe, deputy medical examiner,  
notified and approved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Winklarek</b> Last <b>Winklarek</b>		4. DATE OF DEATH Month <b>Dec. 2,</b> Day <b>19</b> Year <b>65</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1895</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob Mossner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Zimmerman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Edith A. Cizek Same as #2 (daughter)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolism</b> <b>4331</b> DUE TO (b) <b>Curricular fibrillation &amp; clots -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 30, 1965</b> to <b>Dec. 2, 1965</b> , that (I) (we) last saw the deceased alive on <b>Dec. 1, 1965</b> , and that death occurred at <b>1:57 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank R. Shea</b>		22b. DATE SIGNED <b>12/2/65</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK R. SHEA</b>		22d. ADDRESS <b>4100 - 22nd N.E., Wash DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/6/65</b>	
23c. NAME OF CEMETERY OR CREMATOR <b>Lutheran</b>		23d. LOCATION (City, town or county) (State) <b>Middle Village N. Y.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 6 1965</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

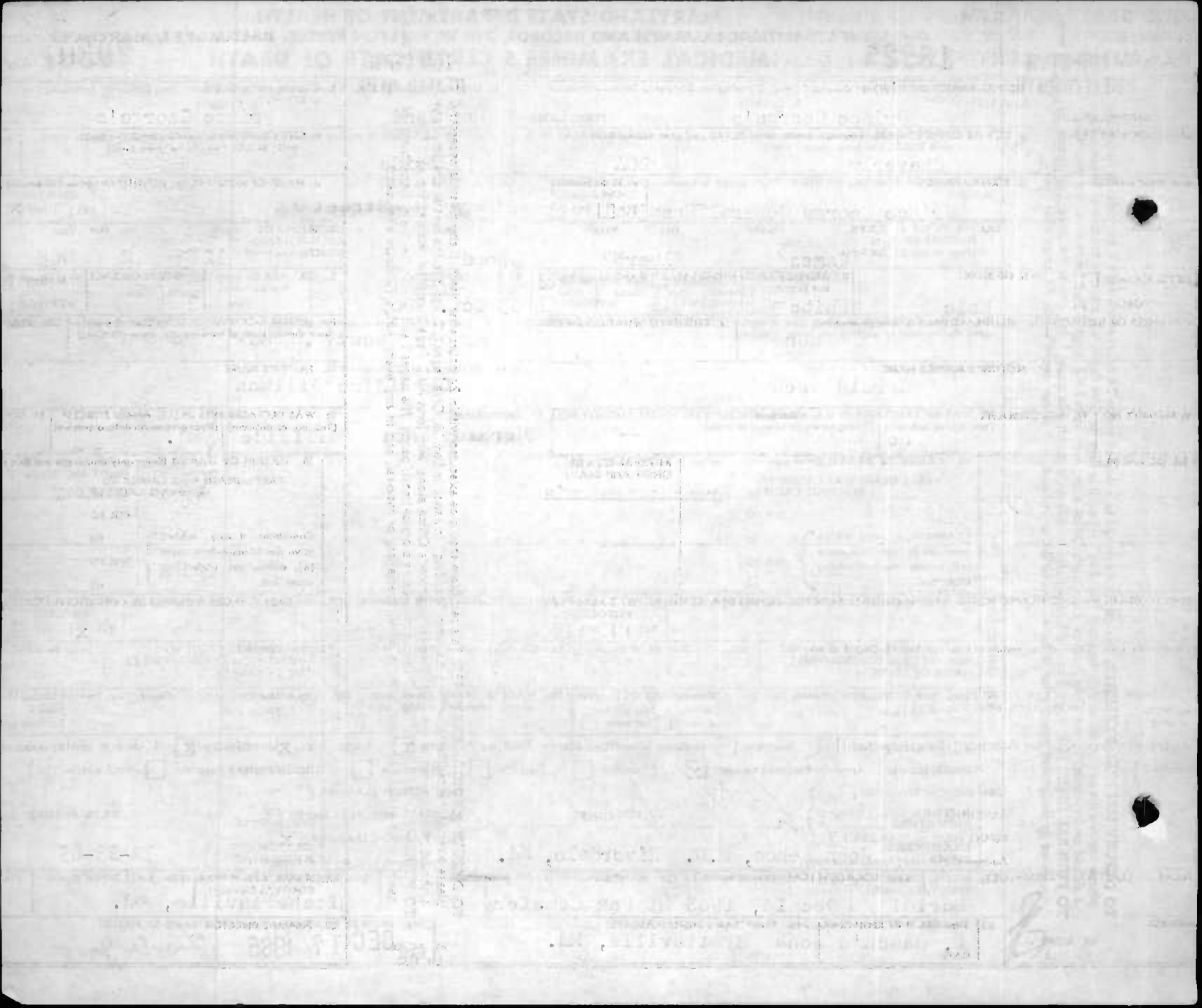
16925

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20307

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside	
c. LENGTH OF STAY in 1b DOA		d. STREET ADDRESS 5801 Main Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Elbert Wood		4. DATE OF DEATH Month Day Year 12 12 1965	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Oct. 1965
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Pro Geo County, Md.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Gerald Wood		14. MOTHER'S MAIDEN NAME Geraldine Dillman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT Address Gerald Wood Hillside Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		DATE SIGNED 12-13-65	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 15, 1965	22c. NAME OF CEMETERY OR CREMATOR Mt Oak Cemetery	22d. LOCATION (City, town, or county) (State) Mitchellsville, Md.
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DEC 17 1965	
		24b. REGISTRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16926 CERTIFICATE OF DEATH 20308											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9524 49th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Theresa A. Yates			4. DATE OF DEATH December 1 1965			5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 6, 1917			9. AGE (In years last birthday) 48 yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Prince George, Md.			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Edgar M. Talbott						14. MOTHER'S MAIDEN NAME Agnes M. Phelps					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.			17. INFORMANT Rose M. Suit			7205 B. Rossburg Dr. College Park, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral marked pulmonary edema 4344 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cardiorespiratory DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov 26, 1965, to Dec 1, 1965, that (I) (we) last saw the deceased alive on Dec 1, 1965, and that death occurred at 2:55 AM, from the causes and on the date stated above.											
22a. SIGNATURE Don B. Cameron						22b. DATE SIGNED 12-1-65			22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D.		
22d. ADDRESS 3503 Perry St. Mt. Rainier, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/4/65			23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet			23d. LOCATION (City, town or county) (State) Washington D. C.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE DEC 6 1965			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND **CERTIFICATE OF DEATH**

16927

20309

<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGE'S</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB</b> c. LENGTH OF STAY IN 1b <b>62 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>ARLINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ARLINGTON</b> <b>83X 3</b> d. STREET ADDRESS <b>1421 21ST STREET SOUTH</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>IDA Lee LOUISE YORK</b> First Middle				<b>4. DATE OF DEATH</b> <b>DECEMBER 15 1965</b> Month Day Year			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>CAUC</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2 APRIL 1886</b> <b>79</b> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>PIKE COUNTY KENTUCKY</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>WILLIAM A HARRIS</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>SARAH ANN TAYLOR</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>HUSBAND</b>		<b>Address</b> <b>SAME AS ITEM #2</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1992 Sudden Death</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Sarcoma left pelvis wall, i metastatic</b> DUE TO (c) <b>Sarcoma of Pelvis &amp; femur severe</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour e.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (and hospital) attended the deceased from 13 Oct 1965 to 15 Dec 1965, that (I) (and hospital) saw the deceased alive on 15 Dec 1965, and that death occurred at 0515 from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>William F Peterson</i> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>WILLIAM F PETERSON, COL, USAF, MC</b>				<b>22b. DATE SIGNED</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>USAF HOSP ANDREWS AFB, MD</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/17/65</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> <b>Arlington Co. Va.</b> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Everly Wheatley Funeral Home</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DEC 20 1965</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>			

MEDICAL CERTIFICATION

152